



Visiting Nurse Association & Blue Water Hospice

Preferred Provider Since 1952

VOLUNTEER WAIVER

Thank you for volunteering to help with the Visiting Nurse Association & Blue Water Hospice. Please read, complete, and sign the following form to participate in this event.

VOLUNTEER INFORMATION (PLEASE PRINT CLEARLY)

Name: _____

Address: _____

Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Volunteer: _____ Phone: _____

VOLUNTEER AGREEMENT

As a volunteer, I release and hold harmless Visiting Nurse Association Health Services and their successors from any and all claims, costs, suits, actions, judgments or expenses upon any damage, loss or injury to me or to my property which may arise from this volunteer event.

I acknowledge that I am fully aware of any and all risks posed by these volunteer activities and that I have no medical condition that prevents me from engaging in them.

I also give permission to be photographed by project partners or the media for use in printed materials, through the internet or through other media outlets.

In signing below, I acknowledge that I have read and understand this volunteer agreement.

Signature: _____ Date: _____

NOTE: If the volunteer is under the age of 18, a parent or legal guardian must sign.

Parent Signature: _____ Date: _____