



VOLUNTEER AGREEMENT



VOLUNTEER CERTIFICATION: I hereby certify that all the information I am providing during the following application process is accurate and correct and I hereby make application for membership in the Maui County health Volunteers chapter of the Hawaii Medical Reserve Corps. I understand that I am applying for a volunteer position and that this is not an application for, or contract of, employment. If any of the information given on this application is incomplete or untrue, I understand that my assignment may be terminated.

VOLUNTEER CONSENT for REFERENCE, CREDENTIAL, and BACKGROUND CHECKS: I hereby give the Healthcare Association of Hawaii and/or the Hawaii Department of Health, permission to inquire into my licenses, credentials, educational background, references, driving record, police records, employment and my volunteer history. I further give permission to the holder of any such records to release this information to the Healthcare Association of Hawaii and/or Hawaii Department of Health or its sponsoring agencies. I understand that the Healthcare Association of Hawaii and the Hawaii Department of Health will only use this information as part of its verification of my volunteer application and periodically for evaluation purposes. I do hereby hold the Healthcare Association of Hawaii and the Hawaii Department of Health harmless from any liability, whether civil or criminal, that may arise as a result of the release of this information. I further hold harmless any individual, agency, business or corporation that provides information or documents to the Healthcare Association of Hawaii and the Hawaii Department of Health. I further understand that there may be additional screening procedures and that I will be required to sign a Code of Conduct.

VOLUNTEER CONSENT for RELEASE of INFORMATION: I do hereby give the Healthcare Association of Hawaii and the Hawaii Department of Health permission to release personal information to local, state, and federal emergency management agencies and other Health and Human Services agencies as needed. In addition, I give my consent to use my image and name as a volunteer in publicity about the program, as needed. There is no expiration on this permission unless notified.

STATEMENT of UNDERSTANDING and CONFIDENTIALITY: I understand that as a volunteer with the Healthcare Association of Hawaii and/or the Hawaii Department of Health, that certain information that I hear and see is strictly confidential and is not to be discussed outside of the Healthcare Association of Hawaii and the Hawaii Department of Health. I agree to observe the policies and procedures of the Healthcare Association of Hawaii and the Hawaii Department of Health.

The Healthcare Association of Hawaii and the Hawaii Department of Health does not discriminate on the basis of race, color, religion, sex, national origin, age, ancestry, marital status, unfavorable discharge from the military, disability or any other legally protected status, in accordance with applicable legal requirements. This is an Affirmative Action/Equal Opportunity Organization.

As part of completing your profile and volunteer application, a user account will be created

for you on our online volunteer management system called E-coordinator. You will be given the log-in information if you wish to manage your own profile on line. However, you will not be placed with or allowed to serve in any volunteer positions until you have been approved for volunteer service based upon the results of your background checks. Should you be disapproved for volunteer service as a result of your background check, your ability to log into our system will be disabled.

Finally, by signing below, you agree to comply with this Volunteer Agreement and the terms and conditions for the use of the E-coordinator website. (Version date 8-8-2007)

Do you agree to comply with this Volunteer Agreement? Yes No

Sign	Date
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