



ADULT Volunteer Information Form

Contact Information

Name: _____ **Birth date:** _____

Address: _____

E-mail address: _____ **Preferred Phone #:** _____

Program(s) volunteering with: _____ **Supervisor(s):** _____

Program(s) volunteering with: _____ **Supervisor(s):** _____

Program(s) volunteering with: _____ **Supervisor(s):** _____

Emergency Contact Information

Name: _____ **Preferred Phone #:** _____

Volunteer's Signature: _____ **Date:** _____

Public Health Emergency Volunteer

****** Would you consider working as a volunteer in a Public Health Emergency Disaster/Event?
Yes No

If yes, you will be provided information to help you decide if you want to register as a Garrett MD Responds volunteer which is a unit of the MD Responds Volunteer Corps.

Please Complete Both Sides



Garrett County, a healthier place to live, work, and play!

garretthealth.org

Toll Free Maryland Department of Health 1-877-463-3464
TDD for Disabled Maryland Relay Service 1-800-735-2258
Equal Opportunity Employer

Consent to Use Information for Public Health Programming and Public Relations

I hereby agree to allow the Garrett County Health Department and its representatives to use my name, photographic likeness, and/or video/audio recording for the purpose of community health education and public awareness.

I give to the Garrett County Health Department, or its authorized representatives, permission to produce, reproduce, display, advertise, loan, or otherwise distribute any and all photographs, film, television productions, or other media made by or for them in the public interest without limitation or reservation.

In giving my consent, I agree to hold harmless the Garrett County Health Department, its agents, or representatives responsible in any way, regarding the use and release of this information.

Print Name: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Volunteer Acknowledgement of Risk

I acknowledge that the volunteer work I agree to perform may involve risk of personal injury or illness. However, I agree to perform the duties assigned to me, and I accept responsibility for my personal safety.

Signature: _____ **Date:** _____

Thank you for your participation!

For Office Use Only: Program: _____
Staff Signature: _____

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