UTAH DEPARTMENT OF HEALTH
VOLUNTEER APPLICATION FORM

DATE _____

NAME_____

ADDRESS _____

CITY AND ZIP _____ PHONE(HOME) _____

PHONE(WORK) _____

ARE YOU PRESENTLY EMPLOYED? Yes □ No □

IF EMPLOYED, EMPLOYER NAME AND ADDRESS _____

_____

YOUR PROFESSIONAL DISCIPLINE (physician, dentist, nurse, PA, etc)

SPECIALTY(if applicable) _____

YOUR REASONS FOR WANTING TO BE A VOLUNTEER _____

_____

_____

PREFERRED ASSIGNMENT

- □ FOURTH STREET CLINIC
- □ HEALTH CLINICS OF UTAH / FAMILY DENTAL PLAN
- □ EPIDEMIOLOGY
- □ OTHER (SPECIFY)_____

NUMBER OF HOURS YOU CAN WORK PER WEEK _____

ANTICIPATED / PREFERRED DAY(S) AND HOURS _____

PLEASE GIVE **TWO** REFERENCES:

NAME _____ PHONE # _____

ADDRESS _____ RELATIONSHIP _____

_____ HOW LONG KNOWN _____

OCCUPATION _____

NAME _____ PHONE # _____

ADDRESS _____ RELATIONSHIP_____

_____ HOW LONG KNOWN_____

OCCUPATION _____

HAVE YOU WORKED AS A VOLUNTEER BEFORE? Yes □ No □

IF SO, FOR WHOM? _____

ADDRESS _____ CITY AND ZIP _____

DESCRIBE DUTIES _____

DO YOU HAVE PRIVATE LIABILITY COVERAGE? YES □ NO □

IF YES, LIST PRIVATE LIABILITY CARRIER _____

This state volunteer liability coverage for the above noted volunteer runs for an indefinite period of time. I hereby certify that I am obligated to give my best effort and maintain high standards of service and honor the confidentiality of clients and information. I agree that I receive no compensation either direct or indirect in exchange for this service. I understand that my license will be verified with DOPL initially and checked annually thereafter as long as I remain an active volunteer.

SIGNED _____

DATE _____

DOPL LICENSE CHECK: Expiration date_____, citations, or disciplinary actions_____?

_____

TO BE COMPLETED BY THE DEPARTMENT OF HEALTH

It is requested that this volunteer applicant be approved to work in the Division's _____

_____ Program under the immediate supervision of _____

Approved: _____ Date _____
(Division Director)

Approved:_____ Date _____
(Human Resource Management)

Department orientation date: _____

Division orientation date: _____

Termination date: _____

Reason for termination: _____

As a volunteer, receiving no compensation, you will be covered by the terms of the Governmental Immunity Act while providing services on behalf of a public entity. Should a claim arise for services performed as a volunteer, the division of Risk Management will defend and indemnify you (secondary to your private coverage, if any, unless otherwise specified) unless fraud or malice, such as sexual harassment were involved in the claim.