

**West Central Health District
Columbus Health Department
2100 Comer Avenue
Columbus, Georgia 31904
(706) 321-6182**

Safe Kids Columbus Partner Application

Contact Information

<p>Mailing Address</p> <p>Company Name: _____</p> <p>Representative: _____</p> <p>Department: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City _____ State _____ Zip Code _____</p>	<p>Please (v) Check Phone for Automated Messaging</p> <p><input type="checkbox"/> Daytime Phone (1): _____ <i>Circle One: Work Home Cell Pager</i></p> <p><input type="checkbox"/> Daytime Phone (2): _____ <i>Circle One: Work Home Cell Pager</i></p> <p><input type="checkbox"/> Evening Phone: _____ <i>Circle One: Work Home Cell Pager</i></p> <hr/> <p>Email: _____</p> <p>Fax #: _____</p>
--	---

Company Website: _____

For statistical purposes only:

Sex: _____ Race: _____ Date of Birth: _____ Marital Status: _____

Special Skills _____

Emergency Contact: _____ Home Phone _____

Relationship: _____ Work Phone _____

How did you hear about Safe Kids Columbus?

Relationship with West Central Health District and Columbus Health Department:

_____ Current employee _____ Never worked for district/department

_____ Former employee _____ Other (Explain _____)

Reference (other than relatives)

Name _____ Phone (_____) _____

Name _____ Phone (_____) _____

I have agreed to participate in the volunteer program at Safe Kids Columbus, led by the West Central Health District-Columbus Health Department and understand that I will not be paid for my services and will not be covered by workers' compensation insurance as are employees of the West Central Health District and Columbus Health Department.

As a participant in the volunteer program, I release the Safe Kids Worldwide, Safe Kids Columbus, West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, volunteers, and other participating agencies and/or organizations, their officers, directors, employees, agents and any participants from all liability of any kind whatsoever including, but not limited to claims, demands, actions or causes which may arise out of my participation and waive all rights which I may have against Safe Kids Worldwide, Safe Kids Columbus, West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents and volunteers, and other participating agencies and/or organizations, their officers, directors, employees, agents, and any participants.

Furthermore, I agree that I will not assist any other person or entity in making a claim or bringing a legal action against Safe Kids Worldwide, Safe Kids Columbus, West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, volunteers, and other participating agencies and/or organizations, their officers, directors, employees, agents, and any participants for any matter which might arise out of my participation in the volunteer program.

I understand that my attendance and involvement in the volunteer program is strictly voluntary and that I am participating at my own risk.

I further irrevocably give Safe Kids Columbus, West Central Health District, Columbus Health Department, the Georgia Department of Human Resources, its assigns and successors, my consent to use my name, any photograph, likeness, image, voice, videotape, sound recording and biography made of me or in which I may be included in whole or part in any and all media, publications, advertising and publicity in connection with my participation with Safe Kids Columbus and any Safe Kids Columbus activity or project. Additionally, by signing this document, I release and forever discharge Safe Kids Worldwide, Safe Kids Columbus, West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, volunteers, and other participating agencies and/or organizations, their officers, directors, employees, agents, and any participants from any and all claims or liabilities of any kind which may arise from the use of my likeness. I acknowledge and agree that I will not receive any compensation in connection with any use of my likeness.

I hereby acknowledge that Safe Kids Columbus is an organization involved in assisting organizations and associations which may from time to time be involved with child care and related matters. I hereby confirm, represent and warrant that I have never been convicted of or charged with a violent crime, or any crime involving or relating to child abuse or neglect, child pornography, child abduction, or any other violent offense, including kidnapping, rape or any sexual offense, nor have I ever been ordered by a court to receive psychiatric or psychological treatment in connection with such crime or crimes.

I have read and agree to the foregoing terms and conditions of this Volunteer Release Agreement.

Signature

Date

If you are under the age of 18, please have a parent or guardian sign the following:

I am the parent or guardian of _____ and I have read and agree to his/her participation in the volunteer program at the West Central Health District and Columbus Health Department pursuant to the foregoing terms and conditions of this Volunteer Release Agreement.

Signature of parent or guardian

Date

**West Central Health District
Columbus Health Department
2100 Comer Avenue
Columbus, Georgia 31904
(706) 321-6182**

Confidentiality Agreement

I, _____, have agreed to participate in the volunteer program at the West Central Health District, Columbus Health Department. I am aware that the nature of my work as a volunteer may expose me to confidential and personal information about clients, staff, and fellow volunteers and interns. My responsibilities in terms of confidentiality have been discussed with me. I understand that all files and information regarding clients are strictly confidential and at no time should be disclosed or revealed to anyone who is not a staff member. I pledge to hold in confidence all personal official information which may come to my attention.

(The West Central Health District, Columbus Health Department, will not defend or represent you if you violate this Confidentiality Agreement and may seek any and all appropriate remedies against you for any such violation).

Signature Date

If under age 18, parental or guardian signature is required:

Parent or Guardian Signature Date

I have discussed this Confidentiality Agreement with the above named volunteer/intern.

Staff Signature Date

Title