

APPLICANT

NAME (Last, First, MI)

--

APPLICANT PHYSICAL LOCATION

STREET ADDRESS

--

P.O. BOX

CITY

STATE

ZIP CODE

--	--	--	--

CONTACT (Applicant)

ALTERNATE CONTACT

NAME

NAME

--

--

TITLE

TITLE

--

--

BUSINESS PHONE

BUSINESS PHONE

--

--

FAX NUMBER

FAX NUMBER

--

--

HOME PHONE (Optional)

HOME PHONE (Optional)

--

--

CELL PHONE

CELL PHONE

--

--

E-MAIL ADDRESS

E-MAIL ADDRESS

--

--

PAGER

PAGER

--

--

THE APPLICANT TO THIS REQUEST HEREIN AGREES TO PROVIDE ASSISTANCE TO THE CLARK CO. HEALTH DEPT. WITH MEDICAL AND PUBLIC HEALTH SERVICES IN RESPONSE TO A MASS EMERGENCY WITHIN THE BOUNDARIES OF CLARK COUNTY, INDIANA OR THEIR AGENCY.

*Rendering of aid is entirely at the discretion of the Aiding Signatory

See Attached

REQUEST FOR VOLUNTEER AID/ASSISTANCE

Clark County Health Department

District 9

TERM AND TERMINATION

- I. This Agreement shall be in effect for a term of one year from the date of signature hereof and shall automatically renew for successive one- year terms unless terminated in accordance with this section.
- II. Any member entity participating herein may terminate its participation in the Agreement by providing written notice to the other member entities. Such notice shall be given at least thirty (30) calendar days prior to the specified date of termination of participation.

JURISDICTION OVER PERSONNEL AND EQUIPMENT

I. The personnel of member entities providing aid and/or assistance shall continue under the command and control of their regular leaders, but operationally those personnel shall be under the control of the incident commander or unified commander designated by the Requesting Member Entity.

II. The Aiding Member Entity rendering aid and assistance shall at all times have the right to withdraw any and all aid and assistance upon the order of its Local Health Officer or his/her designee and upon the notification of the Requesting Member Entity.

The applicant to this request will assist the Clark County Health Department at a mass prophylaxis clinic in the following areas. (Please check all that apply):

Greeting	___	Pharmaceutical Evaluation	___
Form Distribution	___	Dispensing/Vaccination	___
Triage	___	Form Collection	___
Medical Evaluation	___	Patient Traffic Flow	___
Transportation	___	Data Entry	___
Mental Health	___	Translation	___
Briefing	___	Communications/Technology	___
Food Services	___	Facility Maintenance	___

Any additional services/specifics

UPON SIGNING, THE APPLICANT THEREFORE AGREES TO PERMIT THE CLARK COUNTY HEALTH DEPARTMENT TO CONTACT THE SIGNATORY AT THE ATTACHED CONTACT INFORMATION IN THE RESPONSE TO A MASS PROPHYLAXIS EMERGENCY.

The aiding Signatory (_____) understands the terms/liability/jurisdiction of this request and therefore finds it in his/her best interest to sign as an aiding assistant (volunteer) to further stabilize the communities within Clark County boundaries at a time of crisis.

Signature of applicant

Title

Date

Please contact:

DeLynn Rutherford

Public Health Coordinator

Clark Co. Health Dept.

1320 Duncan Ave., Jeffersonville, IN 47130

Office (812) 282-7521

Fax (812) 288-2711