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**Volunteer Application Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASE AND INDEMNIFICATION**

I hereby release and indemnify the Health Wagon/Move Mountains Medical Mission (M7), which is a non-profit organization, and all its respective Board of Trustees, officers, directors, agents, contractors, employees, and assigns from prosecution or presentation of any claim for bodily injury or death or for property loss or damage incurred in connection with Move Mountains Medical Missions or related activities. By signing below, I acknowledge that I have read and understand the contents of this release.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BLOOD-BORNE PATHOGENS TRAINING IS REQUIRED FOR ALL VOLUNTEER *MEDICAL* PERSONNEL**. I hereby certify that I have completed a training / educational program dealing with the risks of exposure to bloodborne pathogens and methods to prevent exposure.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What position do you wish to volunteer for?   
\_\_\_\_ Nurse Practitioner \_\_\_\_Physician \_\_\_\_RN \_\_\_\_ LPN \_\_\_\_Physician Associate \_\_\_\_Dental \_\_\_\_ Clerical Support \_\_\_\_ Phlebotomist Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any professional license(s) that you may hold along with the state that you hold the license(s) in. Please attach copies of any license(s) to this application:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date(s) available to volunteer?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**Applicant Information  
Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State & Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**