



SOUTHWEST DISTRICT HEALTH

Mailing Address: P. O. Box 850, Caldwell, ID 83606
Physical Address: 13307 Miami Ln., Caldwell, ID 83607
Telephone: (208) 455-5318 Fax: (208) 454-7722

For Personnel use only:
Date: _____

VOLUNTEER/INTERN/EXTERN AGREEMENT

Name:						
Street Address:		City:	State:	Zip:		
Home Phone:	Cell Phone:	Other:	Email:			
<input type="checkbox"/> Volunteer	<input type="checkbox"/> Intern	<input type="checkbox"/> Extern	<input type="checkbox"/> Other _____	Classification:	Job Location:	Division:
Bilingual Skills <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please check all that apply: <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> Speak		Please list languages:		
Current Employer/Instructor's Name: (Name, address, phone)						
Do you have any health concerns that require accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				Valid IDAHO Driver's License? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:		
Have you ever entered a plea of guilty, no contest, or had a withheld judgment for any felony or misdemeanor?* <input type="checkbox"/> Yes <input type="checkbox"/> No *An affirmative answer does not automatically eliminate you from consideration. Each situation will be evaluated on a case-by-case basis. If yes, please explain:						

DATES AND LENGTH OF COMMITMENT		JOB DESCRIPTION (Brief description of duties being performed)
Start Date:	End Date:	
Total Hours:	Total Days:	

EDUCATION (Schools attended after High School/Special Training)		
Name (Please provide name and address)	Dates	Degrees/Certificates

PERSON TO NOTIFY IN CASE OF AN EMERGENCY				
Name:				Relationship:
Home Phone:	Cell Phone:	Other:	Email:	

Confidentiality Agreement of Understanding: Subject to termination by either party, the volunteer, intern, and/or extern agrees to furnish his or her services as directed and authorized, and agrees to abide by the rules, regulations, and policies of Southwest District Health. By signing below, the volunteer acknowledges specific understanding that patient or client information is to be held in strict confidence. Such information can only be disclosed to people with a valid need to know.

Volunteer Signature:	Date: ___/___/___
Volunteer Coordinator Signature:	Date: ___/___/___
Division Director Approval:	Date: ___/___/___
District Director Approval:	Date: ___/___/___

Privacy Act Statement: This information is requested by Southwest District Health for the purpose of organizing volunteers, interns, and externs. The above information is needed to extend our liability insurance and worker's compensation. It will not be utilized or released for any other purposes without your permission.