POD *(Point of Dispensing)* Volunteer Application Form

Name _____ _____ _____
Last First MI

Home Address _____ Age _____
Address City/Town State Zip Code

Home Phone # (___) _____ Work # (___) _____ Cell Phone # (___) _____

E-mail (work) _____ E-mail (other) _____

Emergency Contact: _____ Emergency Phone: _____

Can you stand for long periods of time (6-12 hours)? _____**Yes** _____ **No** _____ **Rather have a sitting type Job**

Can you work either day or night hours? _____ **Both** _____ **Just Days** _____ **Just Nights**

For some areas of the POD, we are looking for volunteers with special skills	**For other areas of the POD, we need volunteers to do the following tasks** *Check off all that apply*
____ Accountant _____ Accounting Assistant/Bookkeeper	____ Comforting People
____ Licensed Medical Professional _____ *(please describe)* (If a Medical, Nursing or Pharmacy Student please indicate)	____ Help with Parking and Traffic Control
____ EMT ____ Paramedic	____ Assist with Set-up/Take down of POD equipment
____ Law Enforcement Officer	____ Greeting People
____ Cook / Food Handler ____ Custodian	____ Helping people fill out forms
____ Media Experience – (radio, newspaper, TV)	____ Reviewing & Pre-screening completed forms
____ Manager/Supervisor/Administrator	____ Directing people through the POD
____ Information Specialist (Computer/Technology)	____ Entering Computer Data
____ Digital Radio Operator or HAM Operator	____ Handling Supplies
____ Certified Nurse Assistant ____ Certified Med. Asst.	____ Media Relations
____ Mental Health Provider/Tech. (Lay Counselor)	____ Tracking Supplies & Inventory
____ Licensed Social Worker/Counselor ____ Clergy	____ Operating AV Equipment
____ Receptionist/Secretary/Administrative Asst.	____ Preparing / Serving Food
____ Teacher/Educator ____ Licensed Bus Driver	____ Help Provide Security
____ Military/Security Experience	____ Providing Transportation Services
____ Languages Other than English *(please describe)* _____	____ Loading & Shipping/General Labor
____ Incident Command System Training (ICS-100)	____ CPR ____ First Aid ____ AED
____ **Other** – *(please describe)* _____	____ **I am willing to help in any area**

I am willing to be a volunteer. I understand that my contact information will be kept confidential and will not be shared for any reason other than POD planning/activities.

Volunteer Signature X: _____ Date: _____

Staff Only
Credentialing Required? Yes No Credentialing Results: _____ Initials: _____
(If Yes verify registration with Show-Me Response) If Yes -- Indicate title they are credentialed for (ie. MD, RN, LPN) Credentialing Staff

Volunteer Role: _____

Completed forms are *"For Official Use Only"* and contain confidential personal information

Drop off or mail to:

Vermillion County Health Department
257 Walnut Street
Clinton, In 47842
765-832-3622 765-832-3684 fax
Email Peggie.palmer@vermillioncounty.in.gov