

PeaceHealth – CSJP

EL SALVADOR VOLUNTEER PROGRAM

Uniform Statement of Responsibility, Release and Authorization to Participate in the El Salvador Volunteer Program

I declare my desire to participate in a volunteer healthcare program in El Salvador sponsored by PeaceHealth and the Sisters of St. Joseph of Peace ("CSJP") during the period of _____ to _____. My participation in this program is completely voluntary and is not related to any employment I may have with the sponsoring organizations. I understand and acknowledge that while participating as a volunteer I am not acting within an employment relation with either PeaceHealth or CSJP and am not entitled, because of my participation as a volunteer, to any of the coverages or benefits to which employees of the sponsors are entitled.

If and when I am offered and accept a place in the program, I:

1. Assume full legal and financial responsibility for my participation, with the exception of those financial supports as described in the program.
2. Acknowledge that I have been informed that El Salvador is a developing nation whose water, power and transportation infrastructures; public health standards; health care facilities and services; and police protection are markedly different from those of the United States. I have endeavored to inform myself about the potential difficulties and risks faced by a volunteer in El Salvador and willingly accept them.
3. Grant PeaceHealth-CSJP and their agents and representatives the authority to act in any attempt to safeguard and preserve my health or safety during my participation in the program, including authorizing medical treatment on my behalf and returning me to the United States for medical treatment or in case of an emergency.
4. Agree to conform to all applicable policies, rules, regulations and standards of conduct as established by the program, as well as cooperate with those program requirements and customs of El Salvador to insure the best interest, harmony, comfort and welfare of the program and my experience.
5. Accept termination of my participation in the program if I fail to maintain acceptable standards of conduct of the program, the host country and my placement community.
6. Understand PeaceHealth-CSJP reserves the right to make necessary changes to the program at any time and for any reason, making a reasonable effort to minimize any personal inconvenience to me as a volunteer participant.
7. Agree voluntarily and without reservation to release, indemnify and hold harmless PeaceHealth and the Sisters of St. Joseph of Peace and their respective officers, employees, and agents from any and all liability, loss, damages, costs or expenses (including attorney's fees) which result, either directly or indirectly from my participation in the Program, including any travel incident thereto; provided, however, that such release, indemnity and hold harmless shall not apply to the negligent acts or omission of PeaceHealth and/or the Sisters of St. Joseph of Peace.
8. Acknowledge that I have read this entire document and understand its terms.

Participant's Signature & Date _____

EL SALVADOR HEALTH MISSION TRAVEL INFORMATION FORM

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

PASSPORT NUMBER _____ EXPIRATION DATE _____

BIRTHDATE _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CELL _____

PEACEHEALTH SUPERVISOR / DIRECTOR

NAME _____ TITLE _____

POSITION _____ DEPARTMENT _____

PHONE _____ EMAIL _____

Please complete this form and give a copy to your supervisor. Mail or fax a copy to: Kathy Garcia, Manager, El Salvador Health Mission, P.O. Box 1479, Eugene, OR 97440 - Fax (541) 434-7472
Phone (541) 686-7324 kgarcia@peacehealth.org www.pazsalud.org

EL SALVADOR HEALTH MISSION APPLICATION FORM

NAME _____

WORK DEPARTMENT _____ **TITLE** _____

HOME PHONE _____ **WORK PHONE** _____

E-MAIL _____

SPANISH LANGUAGE PROFICIENCY _____

Volunteer position and dates applying for.

Briefly state why you would like to be considered for this volunteer experience.

What do you hope to gain, personally and professionally, from this experience?

How will you share the experience at work, with friends and family?

SUPERVISORS SIGNATURE _____

**Please complete this form and give a copy to your supervisor. Mail or fax a copy to: Kathy Garcia, Manager, El Salvador Health Mission, P.O. Box 1479, Eugene, OR 97440 - Fax (541) 434-7472
Phone (541) 686-7324 kgarcia@peacehealth.org www.pazsalud.org**