

Volunteer Contact Information

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Would you like to receive our Newsletter to stay Informed about our Epoch Dream Center? :

Email (this will also be used for your background check):

Date of Birth: _____

Are you a college student? YES NO

Are you a veteran? YES NO

VOLUNTEER LIABILITY RELEASE FORM

In consideration of my desire to serve as a volunteer or as the undersigned parent of a minor who desires to volunteer in efforts to be conducted by Epoch Dream Center I hereby assume all responsibility for any and all risk of property loss or damage, bodily injury, or even death that I may sustain while participating in any voluntary effort, or other activity of any nature, including the use of equipment and facilities of the Epoch Dream Center and Nelson’s UMC.

Assumption of Risks: I am aware of the risks of the Epoch Dream Center activities. I understand that Epoch cannot safeguard against all such injuries or damage, and I expressly acknowledge and assume all the risks of the Epoch activities, inherent and otherwise.

Release and indemnity: On behalf of myself or on behalf of my minor child, as a volunteer at the Epoch Dream Center, I, my spouse, my other children, my parents, my heirs, assigns, personal representatives and estate, hereby agree to release and not to sue, and to indemnify, Epoch Dream Center, its directors, officers, agents, volunteers, mentors, employees, Nelson’s UMC and any federal, state or local agencies which have jurisdiction over lands or properties upon which the Epoch Dream Center programs operate (the Released Parties) with respect to any claim of liability, settlement, judgment, award or cost of defense and attorneys’ fees, including negligence, (but not gross negligence) arising from my, or my minor child’s volunteer service at the Epoch Dream Center.

Indemnity: I further agree to indemnify (that is, protect and pay, including costs and attorneys fees) the Epoch Dream Center and other Released Parties from any and all claims, including those brought by my self or my minor child, a member of my/ his or her family, or any other person, arising out of injuries or other losses suffered by myself or my minor child, and which are in any way connected with volunteering at the Epoch Dream Center.

Other: I agree to fully disclose all physical, mental and emotional conditions that could impact the safety or success of the program or that would interfere with any volunteer service or cause me or my minor child to be a danger to my/him/herself or to others.

I agree that any dispute or cause of action arising between me or my minor child and any Released Party, arising from this agreement or otherwise, may be brought only in a court of competent jurisdiction located in Wicomico County, Maryland and shall be construed in accordance with the substantive laws of Maryland. In addition, I understand and agree to the Terms of Agreement as stated in this waiver.

Photo Release: I authorize and agree to the use by the Epoch Dream Center of any and all photographs, videos, and other images and statements by, of, or about my minor child or myself, as deemed suitable by the Epoch Dream Center, without compensation. These photographs, images, videos, and statements may also be shared with organizations that partner with the Epoch Dream Center.

The duration of this agreement is one year from the date of its being signed, if not sooner expressly cancelled or replaced in writing.

Further, I have carefully read the foregoing release and indemnification and understand the contents thereof and sign this release as my own, free act.

Printed Name	Signature	Date
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If under 18 Parent/Guardian Signature	Date
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Emergency Contact and Medical Information

In case of accident or serious illness, the Epoch Dream Center has my permission to seek medical care for myself or my minor child. I authorize appropriate care and treatment be rendered to my minor child or myself by any physician and/or hospital. I will assume responsibility for the emergency care and/or transportation.

Medical Information

Insurance Carrier: _____

Policy Number: _____

Primary Care Physician: _____

Physician Phone Number: _____

Emergency Contact

Name: _____ Relation: _____

Home: _____ Work: _____ Cell Phone: _____

Name: _____ Relation: _____

Home: _____ Work: _____ Cell Phone: _____

Medical Conditions or Allergies: _____

Printed Name

Signature

Date

If under the age of 18, a legal parent or guardian must also sign below.

Parent/Guardian Printed Name

Signature

Date