Colorado Mission of Mercy
Pueblo, Colorado
October 12 – October 15, 2017

Volunteer Service Agreement

The Undersigned, on behalf of myself, my personal representatives, heirs, assigns and anyone else entitled to claim through me, hereby waives any right of recovery, and releases Colorado Mission of Mercy, including its directors, officers, trustees, officials, employees and agents, and other volunteer dental service providers, and any other organization or company or persons acting on their behalf or sponsoring the Colorado Mission of Mercy dental clinic, all of whom are collectively referred to as COMOM herein, from liability related to the Undersigned, in connection with bodily injury including death, personal injury and/or damage to property arising from or out of the Undersigned's activities and participation in volunteer services at the above COMOM dental clinic, and further agrees and undertakes to indemnify, hold harmless and defend COMOM from and against any and all claims, damages, actions, liability and expenses, including attorney's fees and other professional fees in connection with bodily injury including death, personal injury and/or damage to property arising from or out of the Undersigned's activities and participation in volunteer services at the above COMOM dental clinic, EXCEPT, however, that this Agreement shall not operate to waive any coverage or benefits the Undersigned may be otherwise entitled to in the absence of this Agreement under any policy of Worker's Compensation Insurance.

The Undersigned further acknowledges and agrees that COMOM does not assume any responsibility whatsoever for any property of the Undersigned during or in connection with the Undersigned's activities described above related to the COMOM dental clinic described above, and the Undersigned shall not hold COMOM liable for any loss or damage to same.

In compliance with the HIPAA Privacy Act: I further agree to hold in confidence all personal and protected health information I may obtain or observe during and following the above COMOM dental clinic.

If I am a dental or healthcare service provider, I hereby certify, I am licensed to perform the types of dental or healthcare services and treatments I am asked to perform and which are being offered through COMOM volunteer services. I have provided COMOM with the numbers of my current and valid license which allows me to perform such services.

In consideration of being allowed to participate in the COMOM dental clinic described above, by completing and returning this form, I also grant COMOM and its agents the right to use without payment of any kind, my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing COMOM services and its activities in all forms of media in perpetuity.

Volunteer Name (Please Print): ____

Volunteer Signature: ______________________________________ Date: ______________

For Volunteers under 18 years of age:

Name of Guardian (Please Print): ____________________________ Relationship: ____________

Signature of Guardian: ___________________________________Date: ________________

In case of emergency, please contact:

Name (Please Print): ___________________________________ Relationship: _____________

Address: ____Telephone: ________________