



**Volunteer Agreement Form**

Thank you for volunteering with ACMHS/FCMHS!

*To maintain client privacy according to federal laws, all volunteers and visitors to ACMHS/FCMHS are required to sign a confidentiality agreement. Please read and sign the following.*

As a volunteer, I understand my roles and responsibilities are a valuable part of ACMHS/FCMHS, and I agree to carry out my responsibilities to the best of my ability. As I carry out my responsibilities, I may meet donors, community members and participants who wish to remain anonymous. Accordingly, I agree:

- That I have received volunteer orientation training in person or through the ACMHS/FCMHS volunteer orientation video, and understand the contents.
- Not to disclose the identity of ACMHS/FCMHS clients or donors I meet in the course of my volunteer work. If I encounter clients outside of ACMHS/FCMHS, I will wait for them to acknowledge me rather than state where I met them.
- Not to share or discuss ACMHS/FCMHS data on clients, donors, staff, volunteers, corporations, foundations and affiliated organizations.
- Not to access confidential information for purposes other than official ACMHS/FCMHS business.
- Not to take any photographs or record any information while on ACMHS/FCMHS property without specific permission.
- To represent ACMHS/FCMHS in a safe, positive, and professional manner.
- To follow the guidance of ACMHS/FCMHS staff where I am volunteering.
- To ask for help when needed.
- To ask questions when needed.

Printed Name \_\_\_\_\_

Phone #/E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

**Waiver and Release of Liability**

I am aware that any activity, including volunteering with ACMHS/FCMHS and its programs, can expose me to risk of injury or death. I hereby voluntarily and knowingly enter into this waiver and release of liability and do hereby release and forever discharge Anchorage Community Mental Health Services, Inc. (corporate headquarters located at 4020 Folker St, Anchorage AK, 99508) and its staff, board members, agents and volunteers for any physical or psychological injury that I may suffer as a direct result of my volunteer activity at ACMHS/FCMHS.

Printed Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (for participants under 18) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact(s) \_\_\_\_\_