**Project ADAM Wisconsin Volunteer Application**

Project ADAM is a program of the Herma Heart Center at Children’s Hospital of Wisconsin. Thank you for your commitment to supporting our programs to share the importance of CPR and AEDs in schools and communities. We could not do it without you. Please fill out the following Volunteer Application and sign as necessary.

Thank you for your help!

Volunteer’s Name: Today’s Date:

First Last

Address:

Street City State Zip

Phone: Email:

Parent or guardian email (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: Current Employer/School:

Emergency Contact:

Name Phone

**Area of Volunteer Interest:**

* Teaching hands-only CPR/AED to the community
* Administrative support (phone calls, newsletter etc.)
* General community engagement at Project ADAM community events
* Other (please explain):

**How did you learn about the Project ADAM Volunteer program?**

**Please tell us more about yourself, including why you would like to volunteer with Project ADAM:**

**Volunteer Agreement:**

Please read and initial the agreement below:

\_\_\_\_\_\_\_\_ I understand that I am a volunteer for a non-profit organization, and that I am donating my time/service to Children’s Hospital of Wisconsin and Project ADAM. As a volunteer, I understand that I will not receive any compensation, benefits or exchange of privileges in return for my service. I further understand that if I am injured while working as a volunteer for Project ADAM, general liability insurance may be the sole and exclusive remedy for any such injury.

\_\_\_\_\_\_\_\_ I understand that reimbursement for any personal expenses or auto use related to this position shall not be provided unless clearly agreed upon in advance, in writing, with Project ADAM staff.

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\_\_\_\_\_\_\_\_ I understand that failure to perform my assigned duties or follow Children’s Hospital of Wisconsin and Project ADAM policies and practices may result in the termination of the volunteer relationship.

**Media Consent:**

\_\_\_\_\_\_\_\_ I hereby authorize Children’s Hospital of Wisconsin/Project ADAM to take and/or disclose media to include: photographs, video, digital, scans or other images, interview with news media, including newspapers, magazines, wire services, television, radio or Internet. I agree that all reproductions and all copyrights associated with the above described information and media are and shall remain the property of Children’s Hospital of Wisconsin/Project ADAM, its successors and/or assigns. I agree not to request or accept any payment or other consideration in exchange for signing this agreement and for the use of any of the above photography or media materials.

Volunteer Name:

Print Name Signature Date

Parent/Guardian:

*(if volunteer is under 18)* Print Name Signature Date

**Return this form to:**

Tracie Haugen, Project ADAM Coordinator, [thaugen@chw.org](mailto:thaugen@chw.org).

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