



VOLUNTEER REGISTRATION FORM

May 1 - 4, 2008

Remember: Cutoff Date for Pre-Registration is April 25, 2008

Only ONE registrant per form please. Duplicate as necessary.

PLEASE PRINT CLEARLY or TYPE (BOTH SIDES)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (daytime): _____ Email: _____

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

Yes No Will this be the first ArMOM event you have participated in?

DENTIST VOLUNTEERS

Dentist License # _____ State _____ Specialty _____

Please indicate the area you wish to volunteer

Surgery Restorative Numbing Triage

OTHER VOLUNTEERS

Hygienist Assistant Nurse Pharmacist Dental Staff Eqpt. Tech. Other _____

Please indicate the area you wish to volunteer

Assisting Sterilizing Check-in/Check-out Registration
 Floor Runners Volunteer Food Area Central Supply

Yes No I have had a Heptavax and would be willing to work with Dental Instruments (Sterilization).

Yes No Have you been pre-assigned to work in a particular area upon arrival at ArMOM? If so, where _____

Yes No Are you volunteering as a part of a dental team, church, community group or club?
If so, please name _____

GENERAL and DENTAL

volunteers work the following schedule:

Morning

6:00 AM - 12:00 PM
Check in at 5:30 AM

Afternoon

12:00 PM - 5:00 PM
Check in at 11:30 AM

MEDICAL

volunteers work the following schedule:

Morning

5:00 AM - 11:00 AM
Check in at 4:30 AM

Afternoon

11:00 AM - 5:00 PM
Check in at 10:30 AM

I WILL VOLUNTEER ON THE FOLLOWING SESSIONS (Check ALL that apply))

Thursday, May 1

All Day Morning Afternoon

Friday, May 2

All Day Morning Afternoon

Saturday, May 3

All Day Morning Afternoon

T-Shirt Size (Adult Sizes Only) S M L XL XXL XXXL

I can speak and can translate: Spanish German Vietnamese Other _____

An ArMOM packet with agenda and directions will be mailed to all volunteers as volunteer forms are received and will be available on the ASDA website www.dental-asda.org. Pre-Registration deadline is April 25, 2008

If you would like to make a monetary or supply donation, please contact the Arkansas Dental Charitable Foundation office at 501/834-7650 or 800/501-2732.

Mail or FAX to:
Arkansas MISSION OF MERCY
7480 Highway 107
Sherwood, AR 72120
FAX: 501/834-7657

Arkansas Mission of Mercy Volunteer Service Agreement

The undersigned on behalf of themselves and their estate, hereby waives any right of recovery and releases the Arkansas State Dental Association (ASDA), their officers, officials, employees and agents, from liability related to the Undersigned, arising from any and all injury to persons and damage to property, and further agrees and undertakes to indemnify, hold harmless and defend the ASDA 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 Arkansas Mission of Mercy.

The Undersigned further acknowledges and agrees that the ASDA does not assume any responsibility whatsoever for any property of the Undersigned and the Undersigned shall not hold the ASDA liable for any loss or damage to same.

By completing and returning this form, you also grant to the Arkansas State Dental Association and its agents the right to use your picture, voice and other reproductions of your physical likeness in connection with advertising or publicizing Arkansas Mission of Mercy services and its activities in all forms of media in perpetuity.

Print Volunteer Name: _____

Volunteer Signature: _____ Date: _____

For Youth Under 18 Years of Age

Signature of Guardian: _____ Date: _____

In case of emergency, please contact:

Print Name: _____ Relationship: _____

Phone: _____