Ohio Department of Health
Healthcare Provider Volunteer Program – Registration & Survey

Completion of this form is required if applying for volunteer immunity in accordance with sections 3701.071 and 2305.234 of the Ohio Revised Code. **Proof of nonprofit status** must be included along with this registration form. Failure to provide all necessary information will cause a delay in processing your registration. **Email this form and proof of nonprofit status to: dnr@odh.ohio.gov.**

1. ☐ Initial Registration ☐ Annual Registration for Year Starting on Jan 1: _____	2. Director (Last Name) (First Name) (M.I.)		
3. Business/Facility Name:			
4. Street Address			
5. City	6. State	7. Zip Code	8. County
9. Email			
10. Business Area Code and Telephone	11. Fax Area Code and Telephone Number		
12. Federal Tax I.D. Number_____	13. Nonprofit Tax I.D. Number_____		

14. How are you funded? ☐ Philanthropic Organizations ☐ Grants ☐ Religious Organization(s)
☐ Other (explain) _____

15. Do you have a quality assurance program in place? ☐ Yes ☐ No	16. Do you provide 24 hour service? ☐ Yes ☐ No

17. Do you have a shelter or living quarters attached to your facility? ☐ Yes ☐ No

18. What type of service(s) does your facility provide?
☐ Medical (non-emergent) ☐ Medical (scheduled clinics) ☐ Psychiatric (counseling)
☐ Hotline (telephone) ☐ Dental ☐ Other (explain)_____

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Survey of Volunteer Healthcare Professionals

Volunteer Staff	Number of Each
Medical Doctors	
Doctors of Osteopathy	
Registered Nurses	
Licensed Practical Nurses	
Physician Assistants	
Dentists	
Dental Hygienists	
Physical Therapists	
Chiropractors	
Podiatrists	
Dietitians	
Pharmacists	
Medical Technicians	
Medical Assistants	
Dental Assistants	
Orderlies	
Nurse Aides	
Other Categories	
Total	

I solemnly swear/affirm that the answers I have made to each and all questions on this registration are full and true to the best of my knowledge.

Signature of Authorized Agent _____ Date _____

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