

OHIO DEPARTMENT OF HEALTH

OFFICE OF HEALTH ASSURANCE AND LICENSING

REGISTRATION FOR HEALTHCARE PROVIDER VOLUNTEER PROGRAM

1. Registration form shall be typed/printed and submitted **along with proof of non-profit status and volunteer survey form** to the Ohio Department of Health, Office of Health Assurance and Licensing, 246 N. High Street, Columbus, Ohio 43215-0118 or fax the information to (614) 564-2422.
2. Failure to submit the requested forms will cause a delay in processing your registration.

COMPLETION OF THIS FORM IS REQUIRED IF APPLYING FOR VOLUNTEER IMMUNITY In Accordance with Ohio Revised Code 2305.234				
3. Initial Registration: Annual Registration:	4. Director (Last Name) (First Name) (M.I.)			
5. Business/Facility Name:				
6. Street Address				
7. City	8. State	9. Zip Code	10. County	
11. Business Area Code and Telephone	12. Fax Area Code and Telephone No.	13. Federal Tax I.D. Number	14. Nonprofit Tax I.D. Number	
15. How are you funded? <input type="checkbox"/> Philanthropic Organizations <input type="checkbox"/> Grants <input type="checkbox"/> Religious organization(s) <input type="checkbox"/> Other (explain)				
16. Do you have a quality assurance program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Do you provide 24-hour service? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Do you have a shelter or living quarters attached to your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
19. What type of service(s) does your facility provide? <input type="checkbox"/> Medical (non-emergent) <input type="checkbox"/> Medical (scheduled clinics) <input type="checkbox"/> Psychiatric (counseling) <input type="checkbox"/> Hotline (telephone) <input type="checkbox"/> Dental <input type="checkbox"/> Other (explain)				

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** _____