**Request for Reference for a Volunteer Medical Professional**

The below named individual has offered to volunteer at the Community Health Center of Franklin County in the capacity of assisting with efforts to provide COVID-19 vaccinations to CHCFC patients and community residents. Qualifying clinically licensed individuals will be asked to administer COVID-19 vaccine, as well as to monitor patients after administration for any potential side effects or reactions. Volunteers will be expected to have appropriate skill set to give a vaccine and respond to an emergency event should one arise, and should have current CPR or BLS certification. They are also expected to understand and abide by HIPAA regulations protecting the privacy of each person who presents for treatment.

Name of Volunteer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Reference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Volunteer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I believe that the named person is able to perform the duties and services requested and will be a reliable volunteer for the CHCFC COVID vaccination program.

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