BENTON COUNTY VOLUNTEER PROGRAM
MEDICAL TRANSPORTATION

LETTER OF AGREEMENT &
EMERGENCY CONTACT SHEET

BCVP has been asked to place a volunteer for medical transportation for:

NAME
ADDRESS
CITY STATE ZIP
PHONE NUMBER/S
DATE OF BIRTH

EMERGENCY CONTACT
NAME
RELATIONSHIP TO CLIENT
HOME PHONE
CELL PHONE

It is suggested to take the following information with you during transport:

- **Appointment information – date, time, name and address of provider.**
- **A list of medications you are currently taking along with dosage and disbursement schedule.**
- **Names and phone numbers of emergency contacts.**
- **Insurance Card/s**
- **Any other medical information that you would see pertinent in case of emergency.**
- **A copy of your Living Will.**

Upon signing, the client or authorized person making transportation request understand that the volunteers and the Benton County Volunteer Program (BCVP) are covered by auto liability insurance; however, if an incident occurs, the client and/or person making the transportation request will not hold the volunteer or the BCVP liable beyond the limits of said insurance.

I attest that I am in stable mental and physical condition for transport.

I affirm that the information I have provided is accurate and that I have read and agree to the statements above.

SIGNED: _____ _____

(Client or Legal Guardian) **(Date)**

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SIGNATURE OF BCVP STAFF RECEIVING INFORMATION **(Date)**

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