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APPENDIX B

**Health Service Executive Insurance Form- Volunteers COVID 19**

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| --- | --- | --- | --- |
| **Name of Volunteer** | **Where they will based location name and address** | Start date | End date |
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**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Department:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please return all documentation to*

*Insurance Manager, Finance Department, HSE*