Concordia-Health
Official Legal Address
1901 Pennsylvania Avenue NW
Washington, DC 20006
United States
www.concordia-health.org

Volunteer Activity Declaration

(During a Period of Disability)

Member ID: _____

Instructions

This form must be submitted to **Concordia Health** within **one month** of beginning any volunteer activity during your period of disability.

Section 1 – Member Declaration

I, the undersigned,

Full Name: _____

Address: _____

Phone Number: _____

Email: _____

hereby declare that I began the volunteer activity described below on:

Date: ____ /____ /_____

I am requesting authorization from the **Concordia Health Medical Advisor** to perform this unpaid volunteer activity during my period of disability.

Type of Volunteer Activity:

Estimated Duration of the Activity:

I understand that I must promptly notify Concordia Health of any changes to this volunteer activity.

Date: ____ /____ /_____

Member Signature: _____

Section 2 – Organization Confirmation

To be completed by the nonprofit organization.

Organization Name:

Address:

The organization confirms that the individual named above performs the following volunteer activities:

Please describe the volunteer activities in sufficient detail.

The organization further confirms that **no financial compensation or other remuneration** is provided for these activities.

Authorized Representative:

Title:

Date: ____ /____ /_____

Signature: _____

Organization Stamp (if applicable)

End of Form – CH-VOL-001 (v1.0)