Affinity FAMILY CARE
You're Never Alone With Affinity

Telephone: (480) 558-3600 Fax: (480) 558-1806

TRANSPORTATION RELEASE

Employee Name:_____ Date of Birth _____

Address_____City_____State_____Zip_____

As employee of Affinity Family Care, LLC, I give express permission to transport Affinity Family Care, LLC client(s) that I may be assigned to during my scheduled sessions. This transportation can be in the employee's vehicle and/or public transportation. In order to transport, all providers must maintain current driver's license, vehicle registration, and insurance coverage for all vehicles used for transportation, on file at all times. If vehicle insurance is not in the employee's name, proof that the employee is insured on the policy must be provided to AFFINITY FAMILY CARE, by providing the insurance policy declaration page. I agree that my vehicle is safe to transport clients and if for any reason it becomes unsafe I will agree to not transport a client. I also agree that I am not required to transport clients and if requested I can decline. The parent/guardian agrees to train the employee on all vehicle restraints to include seatbelts, car seats, booster seats etc. Providers are instructed to notify parent/guardian before transporting a client to any specified event and/or location. Affinity Family Care, LLC does not reimburse for mileage, and it is the parent/guardians responsibility. I also agree that Habilitation or Attendant Care cannot be billed during anytime providers are transporting the client. Respite can be billed as long as it is written in the Individual Service Plan (ISP) or the Individual Family Service Plan (IFSP).

By signing below, I understand and expressly assume all dangers of transporting the above referenced client and agree to the above/below written statements. I agree that Affinity Family Care, LLC its providers, office staff, directors, officers, employees and management assume no responsibility. I waive all claims arising out of the transport whether caused by negligence, breach of contract or otherwise, and whether for bodily injury, property damage or loss or otherwise, that I may ever have against Affinity Family Care, LLC, its successors and assigns, and its officers, directors, agents (e.g. volunteers), providers, office staff, management and employees, and their executors, administrators and heirs.

By signing below, I agree that I am an employee of Affinity Family Care, LLC. I have had the chance to read and think about the content of this authorization form and willingly without coercion confirm my consent and agree to follow the policies outlined above. I agree to release, indemnify, and hold harmless Affinity Family Care, LLC. and any of their officers, employees, providers, directors, agents (eg. Volunteers) and their executors, administrators and heirs from lawsuit, claim, demand, or action against them for transporting client(s) of Affinity Family Care, LLC, the State of Arizona and the Department of Developmental Disabilities.

This authorization shall be in force until either written notice is given by employee OR the employee file is no longer active with Affinity Family Care, LLC.

_____ _____ _____

Employee Signature **Print Name** **Date**

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