College of Medicine
Volunteer Checklist

UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

This form must be completed and send along with the supporting documentation.
Please electronically send the checklist and supporting documentation to the attention:
HR@comfs.ufl.edu

Volunteer Name (Full Name)	Volunteer UFID	Dept/Division
		Health Outcomes & Biomedical Informatics
Dept Contact (Full Name)	**Dept Contact Phone**	**Dept Contact Email**
Dominick Lemas	(352) 294-5971	djlemas@ufl.edu

☐	***Record of Volunteer Service**
☐	***Volunteer Invitation Letter:** Please describe duties in detail
☐	***Emergency Contact**
☐	***Confidentiality Statement**
☐	* **HIPAA & Privacy- General Awareness -or- HIPAA for Researchers** (only if involved with human research)
☐	***Supervisor Checklist for Health Assessments**
☐	****Volunteer Request to Observe Patient Care or Access Restricted Information**
☐	****Health Assessment (INOP) Form** Required if patient contact or animal contact and etc. Require confirmation that volunteer has been cleared through Workforce Monitor in Peoplesoft.
☐	***Copy of Drivers License (if Foreign National then Gator1 Card or passport)**
☐	*****Copy of I-94 front and back, EAD, I-20 and/or DS2019 if Foreign National**
☐	**Professional Liability Questionnaire (only for faculty)**
☐	* **Mandatory Compliance Training Certificate for all clinical departments or confirmation email from the General Counsel that volunteer is exempt from training**

*** Required for all volunteers**
**** Required if volunteer will have patient observation/contact, access to restricted information, and/or animal or blood contact.**
***** Required if volunteer is a Foreign National**

Please note that the volunteer request cannot be processed in a timely manner if there are items that are missing from the checklist.

Record of Volunteer Service

Section 1—VOLUNTEER INFORMATION

Name:_____

Date of Birth: _____ Phone #:_____

Attach proof of age if volunteer is under the age of 18

Home Address:_____

Street City State Zip

Mailing Address (if different than above):_____

Street City State Zip

Have you ever pleaded "nolo contendere" (no contest) to or been convicted or found guilty (even if adjudication withheld) of a first degree misdemeanor or a felony? ☐ Yes* ☐ No

*If yes, please list the date: _____

Offense and disposition (please explain fully): _____

_____

As a volunteer, I agree to abide by all applicable rules and regulations of the University of Florida and guidelines of this unit and to fulfill the volunteer responsibililties to the best of my ability. I understand that I will receive no monetary benefits in return for the volunteer service I provide and that the university may terminate this agreement at any time without prior notice.

Volunteer's Signature: _____ **Date:** _____

As the parent/guardian of _____, I grant my permission for him/her to participate as an unpaid volunteer for the University of Florida. I further acknowledge that I have completed the Authorization for Treatment form on his/her behalf.

Parent/guardian: _____ _____ _____

Print name Signature Date

Section 2—TO BE COMPLETED BY THE SUPERVISOR

Department where volunteer will work: _____

Supervisor responsible for volunteer's work: _____

Name and title

Supervisor's phone #: _____

Please describe the work the volunteer is expected to perform:

Volunteer's qualifications to perform this work: _____

Volunteer work will begin _____ and end _____

Volunteer's references: _____

Name Relationship to volunteer Phone #

_____

Name Relationship to volunteer Phone #

Supervisor's Signature: _____ **Date:** _____

This form should be maintained by the department in which the volunteer will work.

HRS-RVS1

College of Medicine
Department of Health Outcomes and Biomedical Informatics

PO BOX 100177
Gainesville, FL 32610-0177
352-294-5971
352-265-7221 Fax

Date: _____

Dear _____,

This is to acknowledge your willingness to serve as a volunteer in the Department of Health Outcomes and Biomedical Informatics for the period _____ through _____. You will serve primarily under the supervision of Dominick J Lemas, PhD.

You will have the following assignment (detail description of duties):
Research assistant (student volunteer) duties involve Dr. Lemas's BEACH longitudinal study, BEACH Interview study, Early Life Exposure and Pediatric Outcomes Study and the football stadium project.

Responsibilities include analyzing data from biological specimens collected (such as stool, urine, saliva, human milk, and blood), participant observations, general data collection, molecular biology assays (such as DNA extractions and ELISA techniques), statistical programming, data analysis/entry, participant recruitment strategies, and literature review search.

As a volunteer, you are entitled to workers' compensation and state liability protection under the same conditions as state employees and are responsible for compliance with rules and regulations of the University of Florida.

Sincerely,

_____ _____
Supervisor (must be faculty) Volunteer Signature

EMERGENCY CONTACT
and
CAMPUS DIRECTORY INFORMATION

Please complete this form so that we have a record of whom to contact should an emergency situation arise. Also, take this opportunity to tell us whether you wish to be included in the University of Florida Campus Directory. Submit completed form to **Recruitment and Staffing, P.O. BOX 115002, Gainesville, FL 32611-5002. If you have questions regarding this process, please call 392-2477, SC 622-42477, TDD 1-800-955-8771.** If your home address should change, you will need to update your W-4 card.

EMPLOYEE INFORMATION

Name: _____ UFID #: _____

Home address: _____

Home telephone: _____

University location: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Address: _____

Work/daytime phone: ( ) _____ ext: _____ Home/evening phone: ( ) _____

In the event the above person cannot be reached, please contact:

Name: _____ Relationship: _____

Home Address: _____

Work/daytime phone: ( ) _____ ext: _____ Home/evening phone: ( ) _____

COMMENTS

Are there any important medical conditions, allergies, or other special instructions you would like us to know about in the event of an emergency? (If yes, use space below)

CAMPUS DIRECTORY

Do you wish to have your home address and telephone number printed in the University of Florida Campus Directory (this includes the online telephone directory)? ☐ Yes ☐ No

Employee Signature **Date** **Work phone number**

Confidentiality Statement

- I acknowledge that this statement applies to all members of the workforce, including but not limited to, employees, volunteers, students, physicians, resident physicians, and third parties, whether temporary or permanent, paid or not paid, visiting, or designated as associates, who are employed by, contracted to, or under the direct control of the medical components of the *University of Florida* (UF). The medical components include the Health Science Centers located in both Gainesville and Jacksonville, and all their direct support organizations, designated as *affiliated entities* (affiliates) in the Privacy Manual of the University of Florida.

- I acknowledge that UF has formally stated in the UF Privacy Manual its commitment to preserving the confidentiality and security of health information, whether it is maintained or distributed in paper, electronic, video, verbal, or any other medium or format. I understand that I am required, if I have access to such health information, to maintain its confidentiality and security.

- I understand that access to health information created, received, or maintained by UF or its affiliates in any location is limited to those who have a valid business or medical need for the information or otherwise have a right to know the information. I understand that there are many administrative, physical and technical safeguards in place to protect the privacy and security of this health information, and that any attempt to bypass or override these safeguards is a violation of federal and state laws and the privacy and security policies of the University of Florida.

- I understand that anyone who is authorized to access electronic health information within UF and affiliate systems will be issued a unique user identification and password, and that any person who knowingly discloses their user ID or password to others, uses or discloses another individual's user ID or password, or accesses any electronic protected health information without authorization is subject to disciplinary action, up to and including dismissal. In addition, I understand that all UF and affiliate workforce members must comply with applicable Information Technology Security Policies.

- I understand that approved methods and purposes for access to, uses and disclosures of, and requests for, any and all protected health information created, received or maintained by UF and its affiliates are limited to those described in the *University of Florida* Privacy Manual policies and procedures. I further understand that, with the exception of purposes related to treatment, access to, uses and disclosures of, and requests for an individual's health information must, to the extent practicable, be limited to the minimum necessary to accomplish the intended purpose of the approved use, disclosure or request.

- I understand that any known or suspected violation of the confidentiality or security of health information must be reported to my immediate supervisor or to the Privacy Officer immediately.

I have read the UF Confidentiality Statement and I understand that violation of this policy may result in disciplinary action, up to, and including, dismissal, by the University or its health care affiliated entities, in accordance with UF policies, UFJPI/UFJHI policies, and Rules 6C1-1.008, 6C1-3.047, 6C1-4.016, and 6C1-7.048 of the Florida Administrative Code, as applicable.

I have read the University of Florida Health Information Policy.

Print Name		Signature
Date	UF ID #	College/Dept

Confidentiality Statements are required annually (within every 12 months). Confidentiality Statements "signed" on-line or manually may be printed and placed in the personnel, student, or other appropriate file of the signer or stored on-line.

UF Environmental Health and Safety
UNIVERSITY of FLORIDA

Occupational Medicine Program

Supervisor Checklist for Health Assessments

UF Job Duties that Require a Health Assessment

Check all job duties that apply to position title Volunteer/position number _____.
The job duty links provide descriptions, required forms and locations for more information.

1. For established positions, record the items checked below in myUFL's Organizational Development.
2. For non-established positions (Ex. OPS, volunteers), record the items checked below on the INOP form (https://connect.ufl.edu/ehs/occmed/pages/inop.aspx).

- The Student Health Care Center will need the job duties from either #1 or #2 above before the health assessment is completed.

☐ **Animal Contact*** exposure to vertebrate animals, animal tissues, body fluids or wastes; works with animals or works in animals facilities

☐ **Asbestos Abatement*** individuals involved in an abatement effort

☐ **BioPath*** for those with potential exposure to risk group 3 agents

☐ **Climbing** focus is on not only leg motion but also hand-over-hand motion such as with climbing ladders but not stairs

☐ **Commercial Driver License*** for those required to have a commercial driver license as part of their UF employment)

☐ **Contact with Human Blood*** or Other Potentially Infectious Material (OPIM) includes human body fluids other than feces, urine, tears and sweat

☐ **Frequent reaching above shoulder** includes painting, shelving books, running overhead cable, etc

☐ **Heavy Lifting** 45 pounds and over

☐ **Kneeling** more than 2 hours per day

☐ **Law Enforcement** duties with the University Police Department

☐ **Noise*** (Work in Area of Excessive Noise) noise level defined by OSHA

☐ **Operation of Special Purpose Vehicle** includes industrial or farm equipment

☐ **Patient Contact** having physical or face-to-face contact with a patient, or having contact with potentially contaminated items including (but not limited to) blood and/or body fluids

☐ **Pesticide Use*** individuals who use pesticides as defined in the *Medical Monitoring Program for Pesticide Users*

☐ **Repeated Bending** more than 2 hours per day

☐ **Repetitive Pulling and Pushing**

☐ **Respirator Use*** for individuals required to wear a respirator on a routine or emergency basis

☐ **Scientific Research Diving*** for individuals who participate in UF affiliated research diving

☐ **None of the above job duties apply**

Dominick Lemas		
Supervisor name (print or type)	Supervisor signature	Date

***Requires Periodic Medical Monitoring/Training**

For Departmental Use Only

UF UNIVERSITY of FLORIDA

VOLUNTEER REQUEST TO OBSERVE PATIENT CARE or Access Restricted Information

VOLUNTEER INFORMATION	Volunteer's Name:	Local Street Address (no PO Box):	
	Current Occupation:	City, State, Zip	E-mail:
The volunteer is currently: ☐ **UF Student** ☐ **UF Staff** ☐ **UF Faculty** ☐ **Not affiliated with UF**			**UFID#:**
Enrolled / Working in the College of:	Program or Department:		Student Year:
SPONSORING FACULTY INFORMATION	Sponsor's Name:	Title:	Phone Number:
	Office/Lab Location (Building & Room #):	Department:	Division / Unit

VOLUNTEER ROLE *(check all that apply)*

This volunteer will be performing duties that are primarily related to the following activities. The Sponsor will provide a letter of invitation/ job description that describes in detail the activities for each category checked.

☐ Research ☐ Lab Assistance ☐ Clerical Assistance

Other *(Specify)*:

Dates of Visit/Volunteer Activities:

_____ to _____

1. This volunteer will be observing patient care: ☐ **No** ☐ **Yes**

Please describe the extent of the patient contact: ☐ Observation only ☐ Interacting with patients

Other _____

Prior to observation, attending providers must obtain each patient's consent (verbally or in writing) to the presence of the Volunteer / Observer and document such consent in the patients' health record.

List All Locations for Observation, both on-site and remote, including remote video viewing:

Procedures/Activities to be Observed

☐ Surgery ☐ Hospital Rounds ☐ Clinic Activities ☐ Labs ☐ Research ☐ Other:

2. This volunteer will have access to restricted information: ☐ **No** ☐ **Yes**

If yes, access to the following types of data will be as a result of: ☐ Observing Activities ☐ Other Activities

☐ Names ☐ Addresses ☐ SSN's ☐ Health record #'s ☐ Diagnoses ☐ Genetic Data ☐ Lab Data

☐ Psychol. Test Data ☐ Credit card data ☐ Driver Lic. #'s Other _____

What will the volunteer do with the information? ☐ View ☐ Filing ☐ Data retrieval ☐ Data entry ☐ Data Analysis

Other:_____ Where is the data located? _____

3. Sponsoring Faculty Member and Volunteer understand and agree that:

- _____ _____ *(Initial)* The Volunteer shall not participate in patient care.
- _____ _____ *(Initial)* I understand that Volunteers do not receive a personal access account for Epic.
- _____ *(Initial)* The Sponsoring Faculty Member assumes full responsibility for the actions of the Volunteer and agrees to ensure that the Volunteer complies with all UF Health policies and procedures and applicable state and federal laws and regulations while volunteering.

I certify that the above information is true and complete to the best of my knowledge.
Signature of Sponsoring Faculty Member:

Date of Request:

APPROVAL TO OBSERVE PATIENT CARE	Approved by Dean of College or Designee:	Date:
	Approved by Shands HealthCare Designee:	Date:
APPROVAL TO ACCESS RESTRICTED DATA	Approved by Privacy Office:	Date:

Copies of approved forms go to: •Volunteer •Sponsor •UF Self-Insurance Program •UF Health Shands Privacy Office

UF Privacy Office 352-273-1212 Box 113210, Gainesville, FL 32605 Fax: 352-392-6661 E-mail: privacy@ufl.edu