# USF Health Byrd Alzheimer's Institute

## Request to Volunteer in Patient Care or Clinical Research Area(s)

**Name:**

**USF ID#**

**Local Address:**

**Home Phone:** **Business Phone:**

**Emergency Contact:** **Phone:**

**If under 18 years,** print name of Parent/Guardian:

and provide Parent/Guardian Street Address:

**Background question:**

Have you ever pleaded nolo contendere (no contest) to, or been convicted of, a first degree misdemeanor, a felony, a criminal traffic infraction, or a drug related offense?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, fully explain and attach additional sheets if necessary:

**If USF Student, Staff or Faculty:**

**College:**

**Department:**

**USF Email:**

**Major Area of Training:**

**Faculty Sponsor Supporting Request:**

**Name:**

**Department/Division:**

**Phone Number:**

**USF Email:**

By signing below, the Volunteer understands that he or she will not provide any “hands on” patient care; that at all times he or she will be supervised by the Faculty Sponsor, Administrator or other designated Department Faculty Member/Staff personnel (the “Faculty Sponsor/Designee”); that in the event the volunteer will be present during a patient’s interaction with a health care provider, the patient will be notified in advance of the volunteer’s presence and agree to or decline having the volunteer present during interactions with a health care provider; that he or she that he or she has health insurance; that the Volunteer will wear a Volunteer identification badge at all times and will comply with the applicable standards and procedures of USF/USF Health and the procedures of affiliates as applicable. Volunteer acknowledges that USF does not provide health insurance solely on the basis of the volunteer activity and state law governs the eligibility of volunteers for workers compensation.

**Volunteer Signature:** **Date:**