UF UNIVERSITY of FLORIDA

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: Small Animal Clinical Sciences

Supervisor responsible for volunteer's work: Dr. Julie Levy

Name and title

Supervisor's phone #: 352-273-8722

Please describe the work the volunteer is expected to perform:

Volunteer's qualifications to perform this work: Completed Operation Catnip procedures and safety orientation.

Volunteer work will begin following orientation and end indefinate until termination

Volunteer's references: _____

Name Relationship to volunteer Phone #

_____

Name Relationship to volunteer Phone #

Supervisor's Signature: _____ **Date:** 6/15/14

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

HRS-RVS1 03/07

University of Florida
College of Veterinary Medicine
Volunteer Acknowledgement Form

I, _____ wish to volunteer in Shelter Medicine.

I acknowledge that working in laboratories and/or working with animals carries inherent risks of injury and/or property damage. The following information provides the most common potential hazards, but is not intended to be an exhaustive list of all potential hazards:

Definitions

Allergens – substances capable of producing an allergic reaction.

Carcinogens – substances capable of producing cancer.

Pathogens – bacteria or viruses capable of causing diseases.

Recombinant materials – DNA that has been genetically engineered, usually incorporating DNA from more than one species of organism.

Transgenic – an organism that has had genes from another organism inserted into its genes.

Toxins – poisonous substances produced by living organisms.

Zoonotic diseases – diseases that can be passed from animals to humans.

Potential Hazards

Chemicals – can be unstable, making them prone to explosion. Potential injuries include skin and eye burns, respiratory problems, allergic reactions, skin, eye, and mucous membrane irritation, and illnesses.

Pathogens – found in human, animal and plant tissue can cause infections and acute or chronic illnesses.

Recombinant materials/technology – can interact with the human body and its cells and produce potentially hazardous results.

Mechanical/electrical equipment and instrumentation – can cause electrocution, burns, cuts, scrapes and pinch points. High noise levels can cause temporary or permanent hearing loss.

Radiation/irradiation – can cause skin and eye damage, cellular damage and long-term health problems.

Animals – can bite, scratch, and transmit zoonotic diseases, including but not limited to, rabies, toxoplasmosis, leptospirosis, cat scratch fever, salmonellosis, tetanus, cryptosporidiosis, and various parasitic, bacterial, viral, and fungal infections. Release of allergens may cause respiratory, dermatologic and systemic diseases.

Gas cylinders/compressed gasses – gas cylinders with compressed gasses can explode, causing injury from high speed projectiles. Released gasses can cause eye and skin irritations, respiratory problems, light-headedness, and fainting.

I agree that I will:

1. Always follow the instructions of my supervisor.

2. Always report any accident or injury (regardless of severity) immediately to my supervisor.

3. Always wear the personal protective equipment as directed and dispose of it appropriately. This personal protective equipment includes glasses, gloves, coats/gowns, and other face/body protection as dictated by the hazard being worked with or around.

4. Always keep my hands away from my face and wash them well with soap and water prior to leaving any laboratory or animal facility.

5. Never eat, drink, chew gum, apply lip balm, or touch contact lenses while in any laboratory or animal facility

6. Always wear closed-toe shoes while in any laboratory or animal facility.

7. Always tie back long hair.

8. Always wear clothing that reduces the amount of exposed skin.

9. Always ask questions if I don't understand the safety requirements.

10. Females Only: Notify my supervisor immediately if I become pregnant or suspect I may be pregnant.

I further acknowledge that permission to volunteer may be withdrawn at any time, with or without cause; that I have not been promised, nor do I expect, any compensation of any kind, direct or indirect for my volunteer duties; and that if permission to volunteer is revoked, I would not be entitled to Unemployment Compensation.

I have read the foregoing acknowledgement and had an opportunity to ask questions, and that **I understand it**, and **sign it voluntarily.**

_____	_____
Signature of Volunteer	Date
	July 15, 2014
_____	_____
Signature of Supervisor	Date

UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

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**

Rev. 7/07

Parental/Guardian Authorization for Treatment of Minors (under age 18)

Section 1—TREATMENT AUTHORIZATION

I authorize the provision of medical or hospital care deemed necessary for:

Name: _____ ☐ Male ☐ Female

First Middle Initial Last

Date of Birth: / /

In the event an illness or injury occurs during his or her volunteer service to the University of Florida, I further authorize each of the following:

- I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.
- I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

Section 2—PHYSICIAN/EMERGENCY CONTACT INFORMATION

Family Physician

Name: _____ Phone: _____

Emergency Contact

Name: _____ Phone: _____

Address: _____

Section 3—PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

Signature: _____ **Date:** _____

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

Signature: _____ **Date:** _____

Section 4—TO BE COMPLETED BY THE DEPARTMENT *Department documentation for telephone authorization*

Person Contacted: _____ Phone: _____

Relationship to Volunteer: _____

Witnesses: _____

Description:

Date: _____ Time: _____

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