**Volunteer Request to Observe Patient Care or Access Restricted Information**

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| **VOLUNTEER**  **INFORMATION** | Volunteer’s Name: | | | | Street Address: | | | |
| Current Title or Position: | | | | City, State / Province | | | Country |
| **Current UF Staff / Faculty:** **Current UF Student:** | | | College:  : | | Program/Department  : | | | UFID#:  Student Year: |
| **Sponsoring**  **Faculty**  **Submitting Request** | Sponsor’s Name: | | | | Title: | | | Phone Number:  352-265-0077 |
| Office/Lab Location (Building & Room #):  2036 | | | | Department:  Anesthesiology | | | Division / Unit |
| **Volunteer**  **Role** | **1. A letter of invitation and/or job description for this volunteer’s activities is attached.** | | | | | | | No  Yes |
| **2. This volunteer will be performing duties that are primarily related to: (check all that apply)** | | | | | | | |
| Research: | | | IRB Study #: | | Study PI: | | |
| Lab Assistance | | | Clerical Assistance | | Other: | | |
| **Describe in detail the duties the volunteer will perform for each category checked above, if no job description is attached:** | | | | | | | | |
| **3. This volunteer will be observing patient care: No**  **Yes**  Please describe the extent of the patient contact: Observation only Gathering data directly from patients  Other  **Prior to observation, attending physicians 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 video: | | | | | | | | |
| Procedures to be Observed (i.e. surgery, hospital rounds, clinic, labs, research, etc.) | | | | | | | | |
| **4. 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 / Driver Lic. #’s  Medical/health record #’s  Diagnoses  Lab Data Test Data Genetic Data  Credit card information Other  What will the volunteer do with the information?  View  File  Data retrieval  Data entry  Analysis  Other:      Where is the data located? | | | | | | | | |
| **5. Sponsoring Faculty Member and Volunteer understand and agree that:**   * (Initial) The Volunteer shall not participate in patient care. * (Initial) The Sponsoring Faculty Member assumes full responsibility for the supervision of the Volunteer and agrees to ensure that the Volunteer complies with all policies and procedures of the University of Florida and Shands HealthCare, if applicable, and all 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 Faculty Submitting Request: | | | | | | | Date of Request:  Click here to enter a date. | |
| 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: | |
| Approved forms go to: •Volunteer •Sponsor •UF Self-Insurance Program •UF Privacy Office •Shands Privacy Office | | | | | | | | |

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