

Volunteer Request to Observe Patient Care or Access Restricted Information

VOLUNTEER INFORMATION	Volunteer's Name:		Street Address:	
	Current Title or Position:		City, State / Province	Country
Current UF Staff / Faculty <input type="checkbox"/>	College:	Program/Department:		UFID#:
Current UF Student: <input type="checkbox"/>			Student Year: _____	
SPONSORING FACULTY SUBMITTING REQUEST	Sponsor's Name:		Title:	Phone Number:
	Office/Lab Location (Building & Room #):		Department:	Division / Unit
VOLUNTEER ROLE	1. A letter of invitation and/or job description for this volunteer's activities is attached.			No <input type="checkbox"/> Yes <input type="checkbox"/>
	2. This volunteer will be performing duties that are primarily related to: (check all that apply)			
	<input type="checkbox"/> Research:	IRB Study #:	Study PI:	
	<input type="checkbox"/> Lab Assistance	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> Please describe the extent of the patient contact: <input type="checkbox"/> Observation only <input type="checkbox"/> Gathering data directly from 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 to be Observed (i.e. surgery, hospital rounds, clinic, labs, research, etc.)				
4. This volunteer will have access to restricted information: No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, access to the following types of data will be as a result of: <input type="checkbox"/> observing activities <input type="checkbox"/> other activities <input type="checkbox"/> Names <input type="checkbox"/> Addresses <input type="checkbox"/> SSN's / Driver Lic. #'s <input type="checkbox"/> Medical/health record #'s <input type="checkbox"/> Diagnoses <input type="checkbox"/> Lab Data <input type="checkbox"/> Test Data <input type="checkbox"/> Genetic Data <input type="checkbox"/> Credit card information <input type="checkbox"/> Other _____ What will the volunteer do with the information? <input type="checkbox"/> View <input type="checkbox"/> File <input type="checkbox"/> Data retrieval <input type="checkbox"/> Data entry <input type="checkbox"/> 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.				Date of Request:
Signature of Faculty Submitting 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:
Approved forms go to: •Volunteer •Sponsor •UF Self-Insurance Program •UF Privacy Office •Shands Privacy Office				