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

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