UCLA Health

DIRECT REFERRAL PROGRAM APPLICATION

UCLA Health is committed to a policy of equal opportunity for all applicants for volunteer positions (UCLA Students enrolled in SRP courses are considered "UCLA SRP Students"). UCLA Health does not discriminate against any applicant based on, and considers each applicant without regard to sex, race, color, national origin, ancestry, citizenship, pregnancy, age, marital status, medical condition, physical disability, mental disability, or sexual orientation.

Date: _____ UCLA ID#_____
(If Applicable)

(Check ONE): ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss

Legal Full Name:

Last: First: Middle:

Gender (Check ONE) ☐ M / ☐ F

Permanent address:

Street Address: Apt. #:

City: State: Zip Code:

Phone # (with area code):
( ) -
Cell phone#
( ) -

E-mail address:_____

Birth Date: Month: _____Day: _____Year: _____

Present Employer: _____

Phone #: ( ) -

Emergency contact: Emergency phone #: ( ) -

How did you apply for the assignment you were invited/accepted into?

What are your reasons for applying for this specific assignment position?

Please state your reasons for applying to the specific assignment with any of your special skills and qualities that would benefit your inviting department. (Please do not exceed the allotted space.)

Are you legally eligible to work in the United States?	☐ Yes ☐ No
Are you currently here on a Visa or Visa Waiver (ESTA)?	☐ Yes ☐ No
If yes, please specify type of visa and date of expiration: Visa type:	Expiration Date:
Are you currently attending school? ☐ Yes ☐ No	Name of school:
Previous volunteer or research experiences:	
Foreign languages:	

AGREEMENT AND CERTIFICATION OF INFORMATION

Believing that UCLA Health/DGSOM has need of my services as a Volunteer (for UCLA Students enrolled in SRP, you also agree within the same terms), I agree:

1. To hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, study participants (human research subjects), visitors, families, physicians, or personnel. I agree that I will not seek (unapproved) confidential information concerning any individual.
2. That I am applying for clearance as an unpaid position and not paid employment. I understand and agree that neither this application nor the acceptance or performance of another similar position constitutes an employment relationship or a contract of employment. I further understand and agree that neither this application nor the acceptance or performance of another similar position constitutes a guarantee or promise of future employment.
3. That if I accept this position, I will have a duty to be familiar with UCLA's rules, standards, and policies as they now exist or as they may be modified, added to, or abolished in the future. I agree to comply with the follow these rules, standards, and policies.
4. To purchase and wear the designated UCLA Health uniform and ID at all times while performing my duties in the UCLA Health/DGSOM facility.
5. I certify that the answers given by me to the foregoing questions are true and without omissions. I authorize UCLA Health to investigate and/or verify any information relevant to my suitability.
6. Any person giving misleading or false information will be subject to immediate termination.
7. The Volunteer Services Department reserves the right to terminate my privileges if such action is in the best interest of UCLA Health/DGSOM and/or me. Such termination could result from the failure to comply with general UCLA rules and regulations.

Signature: _____Date: _____

PARENT CONSENT

For youth volunteers (ages 16-17), parental consent is required.

The information contained in this application is correct. I am aware of the various tasks that my daughter/son will be required to perform. My daughter/son has my permission to serve as a Volunteer at UCLA Health, and to also obtain Background Check prior to Volunteering. I give permission for my daughter/son to receive all necessary tests and/or vaccinations, including TB tests, as part of her/his health clearance for volunteer work within UCLA Health.

I understand the responsibility my son/daughter is taking on and will encourage his/her promptness and regular attendance as promised.

Parent signature: _____Date: _____