UCLA Health

Care Extender Program

Completion/Inactivation Request Form

INFORMATION ON RECORD

LAST NAME		FIRST NAME	
EMAIL		PHONE	
ADDRESS		CITY	
STATE		ZIP CODE	

COMPLETION OR INACTIVATION REQUEST

☐ I am requesting to **complete** the program in good standing.

To complete the program in good standing, receive a certificate of completion and a letter of reference from the program, you must submit this form with your hospital ID badge to certify that you have completed at least four active rotations (excluding leave of absences), the required number of hours, AND have finished your last volunteering shift. Committee member extra hours and bonus hours from extra events do not count towards the completion requirement. You must also submit the Alumni Survey. The certificate of completion can be requested within one year of completion of the program.

☐ I am requesting to be **inactivated** from the program.

By filling out this form you are letting us know that you are leaving the program without completing the required 4 rotations of service AND/OR the required number hours of service. You must submit this form as well as return your hospital ID badge. You may request documentation of your hours by completing and submitting the Hours Verification Request Form.

PLEASE BRIEFLY TELL US WHY YOU HAVE DECIDED TO LEAVE THE PROGRAM

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I agree to comply with the requirements in either the completion or inactivation section I've selected above. I am requesting to complete/inactivate from UCLA Health's Care Extender Program. I understand that by completing/inactivating from the program, I am no longer able to continue to shift in the hospital and my role as a Care Extender will conclude. I understand that I must return my hospital issued ID badge with this form in order to be eligible for any documentation release, completion certificate, etc.

☐ By checking off this box, I am confirming that my hospital ID badge is included with this form.

Submit your hospital volunteer ID badge AND this completed form by mailing them to:

UCLA Health
Attn: Care Extender Program
1250 16th Street
Santa Monica, CA 90404

CARE EXTENDER SIGNATURE		DATE	
CE PROGRAM RECEIPIENT		DATE	