# Volunteer/Student Information Sheet

**NAME:** _____ **DOB:** _____

**ADDRESS:** _____ **CITY:** _____

**STATE/ZIP:** _____ **PHONE:** _____

**EMAIL ADDRESS:**_____

**DEPARTMENT TO VOLUNTEER IN:** _____

**IN WHAT CAPACITY (PT, OT, SLP, etc):** _____

**SCHOOL ASSOCIATED WITH:** _____

**IN CASE OF AN EMERGENCY NOTIFY:** _____

**RELATION:** _____ **PHONE:** _____

**CONSENT FOR BACKGROUND CHECK:**
I understand that if WTRC offers me an opportunity to volunteer, they will conduct a background check to be used solely to evaluate my fitness as a volunteer. I understand that if an opportunity to volunteer is offered by WTRC, it will be contingent on the receipt and evaluation of the background check report. If offered an opportunity to volunteer, WTRC will use the information provided in this document along with any additional information necessary to complete a background check. Failure to provide consent or the information required in this consent form will result in the denial of the opportunity to volunteer with WTRC.

I understand that if WTRC permits me to volunteer, my consent will continue to be effective throughout my volunteer appointment to the extent permitted by law. I have carefully read and understand this Background Check Consent Statement and, by my signature below, consent to the release of background check reports to WTRC. This Background Check Consent Statement in original, faxed, photocopied, or electronic form will be valid for any such reports that WTRC may request.

**CONFIDENTIALITY ACKNOWLEDGEMENT:**
I release and agree to indemnify WTRC from and against any and all claims, actions or causes of action which arise from or relate to my involvement at WTRC, including claims, actions or causes of action which arise from, relate to or concern the negligence, or intentional acts of employees, agents or representatives of WTRC.

I further understand that as a volunteer I will have access to confidential patient information, including information regarding a patient's condition, care, records, and personal affairs, and I hereby agree and acknowledge that such information is not to be discussed or disclosed except with those responsible for patient care and treatment. In this regard, it is understood and agreed that all medical information will be held in the strictest of confidence, as even casual conversation may violate a patient's right to privacy. I also understand that I may communicate with patients but may not offer medical advice or opinions or comment specifically on patient treatments provided by the therapist. Finally, it is acknowledged that my involvement at WTRC is at the sole discretion of WTRC, and that the right to volunteer may be revoked for any reason or for no reason whatsoever, and that volunteer will immediately leave WTRC if requested to do so.

**I also acknowledge that I have received a copy of WTRC's Code of Ethical Conduct. I understand it is my responsibility to read, understand and abide by this operating procedure.**

**Signature:** _____ **Date:** _____