

Volunteer Agreement

IF I AM ACCEPTED AS A VOLUNTEER, I AGREE TO:

1. Keep all information regarding patients/clients and hospital business confidential.
2. Give permission for the Volunteer Services staff to discuss my work history and performance with those I have listed as supervisors and references with my potential NIH Clinical Center supervisor(s).
3. Sign in and out each day I volunteer according to the procedures defined by Volunteer Services for my particular area.
4. Volunteer for a minimum period of eight weeks and hours agreed upon for the assignment.
5. Be punctual and regular in attendance.
6. Notify my supervisor(s) in advance if I cannot work as scheduled.
7. Wear the NIH Clinical Center Volunteer I.D. badge while on duty and abide by dress guidelines.
8. Not expect compensation or employment as a result of my volunteer work
9. No smoking. This is a no smoking hospital.
10. Provide documentation of negative TB test within the past one year or a recent chest x-ray.
11. Provide documentation of negative TB test within the past six months or a recent chest x-ray.
12. Perform duties as defined by the position description or my supervisor.
13. Abide by all Volunteer Services guidelines.
14. Abide by all NIH policies and procedures.
15. Attend mandatory orientation and training.

I certify that:

1. I am at least 16 years old.
2. I am not volunteering as a court requirement or as an attorney referral.

Signature of Applicant _____ **Date** _____

PARENT/GUARDIAN OF APPLICANTS WHO ARE UNDER 18 YEARS OF AGE

1. This applicant has my permission to volunteer at the NIH Clinical Center.
2. I have read the above Volunteer Agreement.
3. I will support this applicant in fulfilling the Volunteer Agreement.
4. I understand that my child will be in a medical setting and may have patient contact or be exposed to health hazards or infectious diseases as part of their volunteer assignment.

If you are willing to give permission for the service described above, please sign below.

I give permission for _____
to serve as a Clinical Research Center volunteer.

Parent/Guardian (Print) _____ **Relationship** _____

Signature _____ **Date** _____

Address _____

Day contact # _____ **Evening contact #** _____