Office of Human Resources & Employee Relations

Procedure For Processing A Volunteer Request

Refer to AP 7500 – Volunteers

Whenever there is a need to use a volunteer to perform work in a division/department, the following must be adhered to before the volunteer can perform any work. The work to be performed by the volunteer must not replace work that is normally done by a faculty or classified employee.

1. A "**Volunteer Request Form**" must be completed for each volunteer.
2. The section "**Explanation of Purpose/Need**" is very important. It must show that **the volunteer will not supplant or replace** a regular faculty, classified employee, or laid-off employee.
3. The "**Volunteer Agreement**" must be completed and signed by the individual who is volunteering his/her services. This completed and signed agreement must be attached to the completed Volunteer Request form.
4. The volunteer request package will be reviewed in its entirety by the Office of Human Resources, and the manager/supervisor notified if the request has been approved or not approved. If the request is not approved, it may be resubmitted with the necessary revisions (i.e. clarification of tasks to be performed).
5. If the volunteer will be working with confidential personal information, money, expensive equipment, or minors, the volunteer must be live scanned in accordance with AP 7500.
6. Only after the completed Volunteer Request form has received all of the required approval signatures, and, if applicable, live scan results are acceptable, may the supervisor inform the volunteer that he/she is approved to begin the volunteer assignment.
7. The Human Resources Office will send a copy of the approved Volunteer Request form, Volunteer Agreement, and AP 7500 to the supervisor and the department.
8. The name of the approved volunteer will be submitted on the Personnel Schedule for ratification by the Board of Trustees.
9. If any volunteer is involved in a work related injury/illness, immediately notify the Office of Human Resources, Terry Cleveland, ext. 6033 or Susie Herman ext. 6293.
10. For purposes of worker's compensation, a Pre-designation of Personal Physician form will be provided to the volunteer along with the Volunteer Agreement. The Pre-designation form is voluntary and if completed, must be attached to the signed Volunteer Agreement and returned to the Human Resources Office.

ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

Volunteer Request Form

(Refer to AP 7500 – Volunteers)

This form must be completed in its entirety. The activity or work must NOT commence until all approval signatures have been received, including approval of the Human Resources Office.

Date: _____

Department: _____ **Supervisor:** _____

Period of Service: From: _____ To: _____

Explanation of Purpose/Need. (Must show that the volunteer will not supplant or replace a regular faculty, classified employee, or laid-off employee.) _____

_____

_____

_____

Will the volunteer be working with minors, confidential personal information, money, or expensive equipment?* _____ Yes _____ No

*If 'Yes', the volunteer must be live scanned in accordance with AP 7500.

Name of Volunteer: _____ **Telephone:** _____

Address: _____

(Street Number) *(Street Name)* *(Apt. #)*

_____

(City) *(State)* *(Zip)*

Approval Signatures Required:

_____ _____

Administrator Date

_____ _____

Executive Vice President/Vice President Date

OFFICE OF HUMAN RESOURCES: **_____Approved** **_____Not Approved**

Reason(s), if not approved: _____

_____

_____

Human Resources: Vice President or Director Date

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cc: Supervisor and Administrator
Human Resources (N. Brown) – Personnel Schedule

HR 8/2017; 1/2009; 8/2017, 10/1/2018

Office of Human Resources & Employee Relations

Volunteer Agreement

(Refer to AP 7500 – Volunteers)

Volunteer Assignment: _____

Supervisor Name: _____

I, the UNDERSIGNED, hereby acknowledge and understand that any activities engaged in or work performed for the Antelope Valley College District are entirely on a voluntary basis and are performed with no anticipation of financial renumeration, fringe benefits, insurance coverage of any type, or any other kind of compensation or benefit. It is understood that any activity or work undertaken will be performed only upon special assignment and only under direct supervision of authorized District personnel.

I hereby agree to abide by all District policies and procedures and directions from District personnel and further agree to hold harmless all officers, employees, representatives and agents of the Antelope Valley College District for any and all claims, demands, liabilities, damages, actions, costs of fees, including attorneys fees, arising out of or relating to any activities engaged in or work performed as a result of this assignment.

I hereby acknowledge and understand that the Antelope Valley College District assumes no liability or responsibility for my acts, omissions, debts or obligations as a result of any activity or work in which I may be involved.

I further acknowledge that any personal participation in District work or activities is extended to me by the Antelope Valley College District and may be revoked at any time by written notification.

Print Name: _____ SSN: _____

Signature: _____ Date: _____

cc: Volunteer
Supervisor and Administrator
Human Resources

ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

Form032014

Antelope Valley College

workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O), or medical group, if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury,** must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, in **writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE NAME & ADDRESS:

_____

☐ **I acknowledge receipt of this form and elect not** to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

☐ **If I am injured on the job, I wish to be treated by my personal physician*:**

Name of Physician or Medical Group _____ Phone Number _____

Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury.

The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other documentation of the physicians' agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: _____

☐ ***I agree to treat*** **the above named employee in the event of an industrial accident or injury.** I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

_____ _____

(Physician or Designated Employee of the Physician or Medical Group) Date

Please return completed form to:

Antelope Valley College – Human Resources – 3041 W. Ave. K – Lancaster, CA 93536 *FAX (661) 722-6321