



## ANTELOPE VALLEY COLLEGE

### 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, Judy Cabán, at ext. 6120.
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

cc: Supervisor and Administrator



**ANTELOPE VALLEY COLLEGE**

**Office of Human Resources & Employee Relations**

Human Resources (N. Brown) – Personnel Schedule

**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 remuneration, 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**  
**compensation: Pre-Designation of Personal Physician**

If your employer offers group 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) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 to **qualify as 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 general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

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 worker's compensation medical providers.

**EMPLOYEE NAME:** \_\_\_\_\_

- 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 employer's 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 \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician Address \_\_\_\_\_

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

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*A Personal Physician must be willing to be predesignated and treat you for a worker's 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 **written** documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

**PERSONAL PHYSICIAN 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.
- I do not agree to treat the above employee in the event of an industrial accident or injury.**
- I do not qualify as the employees' personal physician.** I am not an M.D. or D.O. or do not meet the criteria outlined above.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**Please return completed form to:**

**Antelope Valley College, 3041 W Avenue K, Lancaster, CA 93536 Fax: 661-722-6321**