The University Corporation
San Francisco State

Room ADM 361
1600 Holloway Ave.
San Francisco, CA 94132

ucorp.sfsu.edu

Volunteer Acceptance Form

FIRST NAME	LAST NAME		FUND / PROJECT NUMBER /	
STREET ADDRESS	CITY	STATE	ZIP	PRIMARY PHONE #
DATE OF BIRTH	SFSU UIN	EMAIL ADDRESS		
SFSU AFFILIATED: (CHOOSE ONE)	FACULTY	STAFF	STUDENT	
SUPERVISOR'S NAME	EMAIL ADDRESS	PRIMARY PHONE #		

Volunteer Services:

START DATE:	END-DATE:
BRIEF DESCRIPTION OF ESSENTIAL FUNCTIONS, INCLUDING LOCATION:	

Emergency Contact

NAME	ADDRESS	PRIMARY PHONE #

Please Also Complete Designation of Personal Physician Form

Is a driver's license required as part of volunteer responsibilities? Yes No
If yes, please complete Verification of Driver's License & Proof of Automobile Insurance Form.

Is travel required as part of responsibilities requiring reimbursement? Yes No

Required Licenses, Certifications, etc.: ______________________ Expiration Date: __________

______________________ Volunteer Signature / Date

______________________ Project Director's Signature / Date

A background check (including a criminal records check) may be completed before any volunteer can be considered with the UCorp. Failure to complete the background check satisfactorily may affect the volunteer's status or current UCorp volunteers who apply for a position.

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Designation of Personal Physician

An employee may be treated for a work-related illness or injury by a particular medical provider if the University Corporation, San Francisco State has been notified in writing prior to the date of illness/injury. If notification is not on file at the time of injury, the Corporation by law has the right for the first 30 days following that injury to direct medical care and treatment offered to the employee.

Name of Physician/Location of Facility

Address Phone

Designation of Person(s) to Act on my Behalf in Case of an Emergency

Designee:

Name Work Phone Home Phone

Address City/State/Zip Relationship

Other:

Name Work Phone Home Phone

Address City/State/Zip Relationship

Employee Name (Please Print)

Employee Signature Date

Witness Signature (If Applicable) Date