



Volunteer Agreement and Waiver

Volunteer's Name	
Address	
City/State/Zip	

The University of Colorado welcomes you as an authorized volunteer in the Department of Orthopedics at the University of Colorado.

The scope of your volunteer activities includes: hands-off observation of orthopedic patient care.

As a CU volunteer, will not have to undergo a background check.

This invitation will extend for

Your volunteer coordinators will be Kelly Wright and Becky Lewis. Contact information:

Kelly Wright
Undergraduate Education Coordinator
303-724-7354
kelly.wright@ucdenver.edu

Rebecca Lewis
Undergraduate Education Coordinator
303-724-7378
rebecca.2.lewis@ucdenver.edu

You will be required to have the following trainings and follow the location specific safety requirements: HIPPA

As a volunteer you are not an employee or contractor as determined by FLSA 29 CFR §553.103 and will not be compensated monetarily for your volunteerism. There is no expected work product. You are not eligible to receive workers' compensation, but general liability insurance is provided during the period for which you are acting in the capacity of an authorized volunteer.

Volunteer Emergency Contact Information:

Emergency Contact Name(s)

Emergency Contact Phone Number(s)

University of Colorado Notice of Risk and Waiver of Responsibility Agreement

The Colorado Workers' Compensation Act (C.R.S. § 8-40-202) provides that a volunteer is not an employee for workers' compensation purposes. Therefore, as a volunteer, you are not an employee or agent of the University of Colorado for workers' compensation purposes. You are not entitled to receive workers' compensation benefits or any other benefits of employment from the University of Colorado, including, but not limited to, health care, vacation, or sick time. In the event of an injury requiring medical care, you or your personal health insurance will be responsible for payment of all medical care.

Separate and apart from workers' compensation, pursuant to the Colorado Governmental Immunity Act (C.R.S. § 24-10-103(4)(a)), an authorized volunteer is defined by as a "Public Employee" for governmental immunity purposes only.

Use of a privately owned vehicle, including the operation or as a passenger, may be an option while participating in the volunteer activity. The University of Colorado does not provide liability or physical damage insurance coverage on privately owned vehicles. The vehicle owner must provide the liability and physical damage insurance coverage for privately owned vehicle.

If I am a current University of Colorado (CU) employee, I certify that this volunteer activity is not the same or similar to my duties as a CU employee.

I exercise my own free choice to participate in the designated activity. I understand and assume all associated risks. These risks include, but are not limited to:

- ❖ All potential risk associated with participating in hands-off observation in a clinical space.
- ❖ All potential risk associated with being present in a clinical space consisting of various equipment including but not limited to the following types: exercise weights, equipment, and machines (e.g. motorized treadmills, cycle ergometers, resistance training equipment, etc.); large clinical apparatuses; aquatic therapy spaces and related mechanisms etc.
- ❖ All potential risk associated with agreeance at the party member's consent to limit activity to hands-off observation while in the clinical space.
- ❖ All potential risk associated with any activity outside of hands-off observation.
- ❖ All potential risk associated with exposure to any additional risks in the clinical space that may or may not be listed here. Should the party member find him/herself exposed to any additional or aforementioned risks, he/she is to assume full responsibility of their exposure and whatever consequences may result from this exposure.

I agree to assume all risk of personal injury or loss, bodily injury (including death), damage to or loss of, or destruction of personal property, resulting from or arising out of participation in the designated volunteer activity. I also release, waive, indemnify, hold harmless, and discharge the University of Colorado from all claims, damages, and injuries arising out of my volunteer activities.

I hereby certify that I have read and understand the provisions above.

Volunteer Signature

Date

Approved By Name/Department

Date

University of Colorado Volunteer Confidential Disclosure Agreement

I understand that my access to the University of Colorado facilities may be limited in the sole discretion of the Orthopedic Department personnel.

In the course of this volunteer experience, I understand I may have access to certain data and information that is considered confidential, including, but not limited to, information about the Orthopedic Department and University of Colorado activities, patients, personnel, students, and financial or business practices.

I agree that any and all data and information that I may receive or otherwise discover while volunteering is considered "confidential information". I agree that I will not disclose or discuss any confidential information with any third parties while I am volunteering or at any time after my experience is completed. I agree that I will keep such data and information confidential and will comply with all laws and regulations concerning the confidentiality of such records to the same extent as such laws and regulations apply to the University of Colorado, including but not limited to applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8 ("HIPAA") and the requirements of any regulations promulgated thereunder including without limitation the federal privacy standards as contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Standards") and the federal security standards as contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Standards"). I further agree that after my volunteer activity is completed, I will return to the Orthopedic Department any and all documents and copies that I have in my possession that contain Confidential Information.

I hereby certify that I have read and understand the provisions above.

Volunteer Signature

Date

I hereby certify that I have read and understand the provisions above.

Print Name

Volunteer Signature

Date