

Volunteer info:

Name: _____
 Email: _____
 Phone: _____



• Please write the contact information you would like PDS to use to contact you if needed

Pre-Application Training:

Basic LifeSaver / CPR: _____
 Clinic Training/Shadow Session: _____

Immunizations:

Hep B Series: _____
 Tetanus (w/in last 10 years): _____
 TB test within last 12 months: _____

Application:

Type:		
New	Renewal	
<input type="checkbox"/>	<input type="checkbox"/>	UCSD PDS Application Checklist
<input type="checkbox"/>	<input type="checkbox"/>	Volunteer Appointment Form Completed and Signed: <input type="checkbox"/> <i>NON-USA Citizens, Attach VISA.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Oath/Patent Signed & Witnessed on or before first day
<input type="checkbox"/>	<input type="checkbox"/>	Personal Data Form
<input type="checkbox"/>	<input type="checkbox"/>	Volunteer Agreement
<input type="checkbox"/>	<input type="checkbox"/>	Volunteer Expectations
<input type="checkbox"/>		Confidentiality Agreement
<input type="checkbox"/>		Emergency Notification Form
<input type="checkbox"/>		HIPAA Module 1
<input type="checkbox"/>		HIPPA Module 2
<input type="checkbox"/>		Background Check
<input type="checkbox"/>		UCSD PDS Emergency Contact
<input type="checkbox"/>		UCSD PDS Shadow Session
<input type="checkbox"/>		UCSD PDS Photobook
<input type="checkbox"/>		UCSD PDS MyPDS Registration

FOR INTERNAL USE	Background Check Date & Result:	
	Background Check Result:	
	Date of Original Form Submission:	
	Date of Approval:	
	Start / End Date	

* Forms sent to Cheryl Minas (DEPT.HR) (Mail Code 8912C)

*Leave this page blank.

- Volunteer Appointment Request Checklist:
- Volunteer Appointment Form
 - Oath and Patent Acknowledgement
 - Personal Data Form
 - Volunteer Agreement
 - Volunteer Expectations


UC San Diego
HEALTH SCIENCES

Volunteer Appointment Form

Name _____
Last First Middle

Begin Date _____ / End Date _____ **Date Prepared** _____

Home Dept Unit Code 00301 Home Dept Name Family Medicine & Public Health Mail Code 8912

Department Contact Cheryl Minas Telephone _____ Email cminas@ucsd.edu

Citizenship Status (please check): Citizen Yes No Visa Status (if applicable): _____

<p>UC Student Status (please check)</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Not Registered</p> <p><input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate</p>	<p>Are you currently on UCSD pay status?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please check one of the following:</p> <p><input type="checkbox"/> Career <input type="checkbox"/> Contract <input type="checkbox"/> Limited <input type="checkbox"/> Student</p>
<p>List any near relatives who are UCSD employees Families employed at UCs</p>	

Title: **Volunteer** Title Code: **9900/Without Salary**

Describe the nature of volunteer efforts / Comments:
Assist as needed at UCSD Student Run Free Dental Clinic sites

I am volunteering my services to the University of California, San Diego for the purpose of _____ experience in the FMP/UCSD Free Clinic Project Department solely for my personal reasons or benefit without promise or expectation of compensation or University benefits. My volunteer services will not be performed in my regular department or in connection with regular duties, and I understand that I will not displace a regular status employee.

Volunteer's Signature _____ Date _____

Departmental Authorization Signature _____ Date _____

Anne Crane _____ 0696 _____ (858) 822-5511
 Prepared by Mail Code Telephone

**** Please forward all original forms listed above to Health Sciences Human Resources at mail code 0742 for review and authorization. Health Sciences HR will e-mail an approved copy of the Staff Volunteer Appointment Form to the department.**

Human Resources Signature _____ Date _____



- If not a citizen, please attach the appropriate visa/permanent resident card/employment card
- Registered only if a UC student and undergraduate or graduate. Graduate means graduate student. If you have graduated from a UC or attend a different university, please check not registered.

- Yes or no. Yes only if you get paid from working, not scholarships and etc.

- Make sure to sign and date



PERSONAL DATA FORM
UPAY544-6 (R9/00) FO-2195

EMPLOYEE #	NEW EMPLOYEE #	DATE
DEPARTMENT	Family Medicine & Public Health	
SUFFIX	PRIOR NAME (NAME CHANGE ONLY)	PERSONNEL PROGRAM CODE A - ACADEMIC 1 PROFESSIONAL & SUPPORT STAFF 2 - MANAGEMENT & SR PROFESSIONAL

• Write your name

CHECK BOX IF NAME CHANGE

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) (19-44)

TYPE OF ACTION (check appropriate box)

<input type="checkbox"/> EMPLOYMENT (complete all information-attach to PAF)	<input type="checkbox"/> DATA CHANGE (complete only information to be changed)	<input type="checkbox"/> SEPARATION (complete only if permanent address has changed)
--	--	--

ADDRESS INFORMATION

PERMANENT ADDRESS, YOUR MAILING ADDRESS			CAMPUS MAILING ADDRESS		
LINE 1-STREET ADDRESS			e-mail:		
LINE 2-STREET ADDRESS			CAMPUS PHONE 1		CAMPUS PHONE 2
CITY	STATE	ZIP CODE	HOME PHONE		SPOUSE'S NAME
COMPLETE ONLY IF YOUR MAILING ADDRESS IS OUTSIDE THE U.S.			DISCLOSURE OF INFORMATION		
FOREIGN PROVINCE, STATE, COUNTY, DISTRICT, REGION, etc.		FOREIGN POSTAL CODE	CHECK THE FOLLOWING ITEMS YOU WANT DISCLOSED TO OUTSIDE PARTIES WHO REQUEST THIS INFORMATION.		EMPLOYEE ORGANIZATIONS: DO YOU WANT YOUR HOME ADDRESS RELEASED TO EMPLOYEE ORGANIZATIONS?
FOREIGN COUNTRY	FOREIGN CODE	PERMANENT ADDRESS	HOME PHONE NUMBER	SPOUSE'S NAME	YES NO

• Write your permanent address

• Write your UC email if you have one. This is for university use only.

• Do you give UCSD the permission to share your information with other departments? If yes, select which information.

STUDENT STATUS AND EDUCATION

UC STUDENT STATUS		MARK HIGHEST DEGREE OBTAINED		YEAR AWARDED
1 - Not Registered 2 - Not Reg. Deg. Cand 3 - Undergraduate 4 - Graduate		5 - Not Reg. Deg. Cand / Other Campus 6 - Undergraduate / Other Campus 7 - Grad / Other Campus		Institution: _____ No Acad. CERT. (N) H.S. OR EQUIV. (H) TRADE CERT. (T) ASSOC. (A) BACH. (B) MAST. (M) PROF. (P) DOCT. (D)
UC Student Units this Status Term				

• Registered only if a UC student and undergraduate or graduate.

Graduate means graduate student. If you have graduated from a UC or attend a different university, please check not registered.

• Please write the # of units of classes you're taking at a UC THIS quarter

• Please make sure to write the institution you received your highest degree.
• Check the box of the highest degree you received.
• Write the year you received your degree.

PRIOR EMPLOYMENT (other than UC or State)

PRIOR OR CONCURRENT UC/STATE EMPLOYMENT (Include ERDA Labs)

EMPLOYED FROM	EMPLOYED TO	EMPLOYER NAME	EMPLOYED FROM	EMPLOYED TO	UC CAMPUS & DEPARTMENT OR NAME OF STATE AGENCY	RETIRE SYS NAME
---------------	-------------	---------------	---------------	-------------	--	-----------------

PERSONAL INFORMATION

RELATIVES EMPLOYED AT UC?

SEX MALE (M) FEMALE (F)	DATE OF BIRTH	PROFESSIONAL LICENSE/CERTIFICATE NUMBER (IF APPROPRIATE)	EXP. DATE	INDICATE NAME HERE AND RELATIONSHIP AND DEPARTMENT IN REMARKS
-------------------------------	---------------	--	-----------	---

• Please fill out your personal information.

• Do you have any relatives at the UC system? Check yes or no.

REMARKS

REMARKS

Employee Signature:	Phone Number:	Date:
---------------------	---------------	-------

• Make sure to sign, date, and write your phone number.

	UNIVERSITY OF CALIFORNIA STATE OATH OF ALLEGIANCE. PATENT POLICY, AND PATENT ACKNOWLEDGMENT		EMPLOYEE'S NAME (Last, First, Middle Initial)	DATE PREPARED Mo/Dy/Yr
	UPAY585 (R 11/2011) E0420 71443-180	EMPLOYEE ID	DEPARTMENT Family Prev-Med Health	EMPLOYMENT DATE Mo/Dy/Yr
STATE OATH OF ALLEGIANCE I do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.				
Taken and subscribed before me on: _____ Mo/Dy/Yr			Signature of Officer or Employee: _____	
Signature of Authorized Official: _____ Title: Sr Community Health Program Representative County: San Diego State: CA		(Do not sign until in the presence of proper witness.) NOTE: No fee may be charged for administering this oath.		
The oath must be administered by either (1) a person having general authority by law to administer oaths—for example, Notaries Public, Civil Executive Officers (Gov. Code Sec. 1001), Judicial Officers, Justices of the Peace, and county officials named in Gov. Code Sections 24000, 24057, such as, district attorneys, sheriffs, county clerks, members of boards of supervisors, etc., or (2) by any University Officer or employee who has been authorized in writing by The Regents to administer such oaths.				
WHO MUST SIGN THE OATH: All persons (other than aliens) employed by the University, in common with all other California public employees, whether with or without compensation, must sign the oath. (Calif. Constitution, Article XX, Section 2, Calif. Gov. Code Sections 3100-3102.)		WHERE OATHS ARE FILED: The Oaths of all employees of the University shall be filed with the Campus Accounting Office.		
All persons re-employed by the University after a termination of service must sign a new Oath if the date of re-employment is more than one year after the date on which the previous Oath was signed (Calif. Gov. Code Sec. 3102.)		FAILURE TO SIGN OATH: No compensation for service performed prior to his subscribing to the Oath or affirmation may be paid to a University employee. And no reimbursement for expenses incurred may be paid prior to his subscribing to the Oath or affirmation. (Calif. Gov. Code Sec. 3107.)		
WHEN OATH MUST BE SIGNED: The Oath must be signed BEFORE the individual enters upon the duties of employment (Calif. Constitution, Article XX, Section 3; Calif. Gov. Code Sec. 3102.)		PENALTIES: "Every person who, while taking and subscribing to the Oath or affirmation required by this chapter, states as true any material which he knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one or more than 14 years." (Calif. Gov. Code Sec. 3108.)		
PATENT ACKNOWLEDGMENT This acknowledgment is made by me to The Regents of the University of California, a corporation, hereinafter called "University," in part consideration of my employment, and of wages and/or salary to be paid to me during any period of my employment, by University, and/or my utilization of University research facilities and/or my receipt of gift, grant, or contract research funds through the University. By execution of this acknowledgment, I understand that I am not waiving any rights to a percentage of royalty payments received by University, as set forth in the University of California Patent Policy, hereinafter called "Policy." I also understand and acknowledge that the University has the right to change the Policy from time to time, including the percentage of net royalties paid to inventors, and that the policy in effect at the time an invention is disclosed shall govern the University's disposition of royalties, if any, from that invention. Further, I acknowledge that the percentage of net royalties paid to inventors is derived only from consideration in the form of money or equity received under: 1) a license or bailment agreement for licensed rights, or 2) an option or letter agreement leading to a license or bailment agreement. I also acknowledge that the percentage of net royalties paid to inventors is not derived from research funds or from any other consideration of any kind received by the University. The Policy on Accepting Equity When Licensing University Technology governs the treatment of equity received in consideration for a license. I acknowledge my obligation to assign, and do hereby assign, inventions and patents that I conceive or develop 1) within the course and scope of my University employment while employed by University, 2) during the course of my utilization of any University research facilities, or 3) through any connection with my use of gift, grant, or contract research funds received through the University. I further acknowledge my obligation to promptly report and fully disclose the conception and/or reduction to practice of potentially patentable inventions to the University authorized licensing office. Such inventions shall be		to determine rights and equities therein in accordance with the Policy. I shall promptly furnish University with complete information with respect to each. In the event any such invention shall be deemed by University to be patentable or protectable by an analogous property right, and University desires, pursuant to determination by University as to its rights and equities therein, to seek patent or analogous protection thereon, I shall execute any documents and do all things necessary, at University's expense, to assign to University all rights, title, and interest therein and to assist University in securing patent or analogous protection thereon. The scope of this provision is limited by Calif. Labor Code Sec. 2870, to which notice is given below. In the event I protest the University's determination regarding any rights or interest in an invention, I acknowledge my obligation: (a) to proceed with any University requested assignment or assistance; (b) to give University notice of that protest no later than the execution date of any of the above-described documents or assignment; and (c) to reimburse University for all expenses and costs it encounters in its patent application attempts, if any such protest is subsequently sustained or agreed to. I acknowledge that I am bound to do all things necessary to enable University to perform its obligations to grantors of funds for research or contracting agencies as said obligations have been undertaken by University. University may relinquish to me all or a part of its right to any such invention, if, in its judgment, the criteria set forth in the Policy have been met. I acknowledge that I am bound during any periods of employment by University or for any period during which I conceive or develop any invention during the course of my utilization of any University research facilities, or any gift, grant, or contract research funds received through the University. In signing this acknowledgment, I understand that the law, of which notification is given below, applies to me, and that I am still required to disclose all my inventions to the University.		
NOTICE: This acknowledgment does not apply to an invention which qualifies under the provision of Calif. Labor Code Sec.2870 which provides that (a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either: (1) Relate to the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or (2) Result from any work performed by the employee for the employer. (b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable. In any suit or action arising under this law, the burden of proof shall be on the individual claiming the benefits of its provisions.		_____ Employee/Guest Name (Please print): _____ Employee/Guest Signature: _____ Date: _____		
RETENTION: Accounting: 5 years after separation, except in cases of disability, retirement or disciplinary action, in which case retain until age 70.		_____ Witness Signature & University Acceptance: _____ Date: _____		
Other Copies: 0-5 years after separation				

← Write your name: Last, first, middle initial

← Please sign this oath.

← Print your name, and sign and date below it

PLEASE SIGN STATE OATH AND PATENT ACKNOWLEDGMENT

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/ or peer review activities.
2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all employee records/medical records, proprietary information and other confidential information relating to UCSD Health Sciences and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.
3. I shall only access or disseminate employee/patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of UCSD Health Sciences, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of UCSD Health Sciences affairs.
4. UCSD Health Sciences performs audits and reviews employee/patient records in order to identify inappropriate access.
5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.
6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.
7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.
9. My obligation to safeguard patient confidentiality continues after my termination of employment with the University of California.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the University of California may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from the University of California.

Print Name:	Signature:
Department: Family Medicine & Public Health	Dated:

← Print your name, sign and date.

Routing: Please complete the form and return it to your hiring department.



UC San Diego HEALTH SCIENCES

Health Sciences Volunteer Agreement Form

Position Title: Dental Chairside Assistant

Volunteer Name:

Supervisor: Sara Hamzeinejad

Number of Hours Per Week: 5

• Print your name.

Describe all volunteer responsibilities.

Volunteers may perform any of the following:

- Seating patients in the treatment area.
- Passing requested instruments to the dentist during dental procedures.
- Providing assistance in the office with tasks such as appointment scheduling, record keeping.
- Manage patient records and filing.
- Assist the dentist directly at chairside with operative, oral surgery, orthodontic, and a wide range of other procedures.
- Provide oral hygiene instructions, preventive dentistry & dietary counseling.

Describe the training and orientation that the volunteer will receive.

Student volunteers orientation provides introduction to Dental Instruments and Supplies, general safety information, and patient management protocols.

I have reviewed and discussed the responsibilities and training for this volunteer appointment.

Volunteer Signature

Date

• Sign and date.

Supervisor Signature _____

Date _____



Volunteer/Supervisor Expectations

Volunteer: As the volunteer enters the department, he or she is expected to assume, as much as possible, the role of a regular staff member. The responsibilities include:

1. Adhering to department policies, procedures and rules governing professional staff behavior.
2. Adhering to department policies governing the handling of confidential information.
3. Assuming personal and professional responsibilities for his or her actions and activities.
4. Utilizing a courteous, enthusiastic, open minded, and critical approach to all projects.
5. Being consistent and punctual in the submission of all work assignments.
6. Providing the supervisor with periodic progress reports.

<hr/> <p>Volunteer Signature</p>	<hr/> <p>Date</p>
----------------------------------	-------------------

← • Sign and date.

Supervisor: It is the responsibility of the supervisor to provide direct on-the-job supervision of the volunteer that includes the following:

1. Orienting the volunteer to the department's structure and operation.
2. Orienting the volunteer to the company's policies and procedures regarding appropriate office hours and leave policies.
3. Introducing the volunteer to staff.
4. Assigning tasks and responsibilities that are consistent with the volunteer's role in the department.
5. Meeting regularly with the volunteer to answer questions and offer constructive feedback.
6. Evaluating and communicating the performance of the volunteer.

Supervisor Signature

Date

UCSD Pre-Dental Society Emergency Contact Form:

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Volunteer Info:

Name:	
Email:	
Phone:	
Signature:	

- Please write down email and phone numbers that you would like PDS to use in case of an emergency. You must complete all sections.

Emergency Contact Info:

First Name:	
Last Name:	
Relation:	

Address:	
City:	
State:	
Zip Code:	

Daytime Phone:	
Message or Home Phone:	

HIPAA Module 1 and 2

- Please read through HIPAA Modules 1 and 2 posted on the website. Print and sign your name on the last 1 or 2 pages of the slides to confirm that you have read through both.
 - The required pages are included in the proceeding 3 pages.
- <http://fdc-pds.ucsd.edu/volunteer/clinics.php>

Acknowledgment of Training

Topic: Security Awareness Training

- Instructions: Print this page, fill-in your name and provide it to your supervisor for “proof of training” completion. Supervisor: Retain this certificate with personnel training records.

CERTIFICATE

Security Awareness Training Module completed by:

- Print Name: First: _____ MI: _____ Last: _____
- Date of Training: _____; Your Initials: _____
- Department: _____ / Campus: _____

Confidentiality Statement

Web-link to UCSD Health Sciences Confidentiality Agreement, <http://health.ucsd.edu/compliance/hipaa.shtml>

- The protection of health and other confidential information is a right protected by law and enforced by individual and institutional fines, criminal penalties as well as UCSD policy. Safeguarding confidential information is a fundamental obligation for all employees, clinical faculty, house staff, students and volunteers.
- I understand and acknowledge that:
 1. I shall protect the privacy and security of confidential information at all times, both during and after my employment with the University of California has terminated.
 2. I agree to (a) access, use, or view confidential information to the minimum extent necessary for my assigned duties; and (b) disclose such information only to persons authorized to receive it.
 3. I understand that UCSDHS tracks all user IDs used to access electronic records. Those IDs enable discovery of inappropriate access to EITHER patient records or employee records.
 4. Inappropriate access and unauthorized release of protected information will result in disciplinary action, up to and including termination of employment, and will result in a report to authorities charged with professional licensing, enforcement of privacy laws and prosecution of criminal acts. The Office of Health Information Integrity (OHII) may levy penalties to **individuals** or **providers of healthcare** of **\$2,500 - \$25,000 per violation**.
 5. User IDs cannot be shared. Inappropriate use of my ID (whether by me or anyone else) is my responsibility and exposes me to severe consequences.

Print Name: _____ / Date: _____

Certification of Training

- I have read the UCSD Privacy / Security training materials and confidentiality statement and agree to abide by UCSD policy and Federal / State privacy laws.
- Print name: _____
- Department name: _____ / UCSD
- Employee number: _____ *<if known>*
- Non-UCSD workforce member ID: _____
 - Indicate your date of birth and last 4 digits of your last name.

UCSD Pre-Dental Society Shadow Session:

This form is REQUIRED when attending a shadow session in any clinic listed below. After attending a shadow session, this form must be submitted with your application for processing.

Volunteer Information:

Name: _____

Email: _____

Phone: _____



• Please use the contact information you would like PDS to use.

Training Verification:

Manager Name:	
Signature:	
Date of Training:	
Clinic:	<input type="checkbox"/> Baker Clinic <input type="checkbox"/> Downtown Clinic <input type="checkbox"/> Lemon Grove Clinic <input type="checkbox"/> Pacific Beach Clinic

*** Please take this page to your Shadow Session!!!**

- How to sign up for a shadowing session?
 - You must be on the PDS email list serve to receive emails regarding volunteer signups.
 - You will sign up for a shadow session the same way as regular volunteers, but you will select shadower at the very end instead of chairside or X-ray tech.

UCSD Pre-Dental Society Photobook:

Your photo is REQUIRED for your participation in the UCSD Pre-Dental Society / Free Dental Clinic Project.

Volunteer Info:

Name: _____
Email: _____
Phone: _____

Photographer Info:

Photographer Name:	
Signature:	
Date Photograph Taken:	

* Photos must be take by PDS during GBMs or specified PDS events.

UCSD Pre-Dental Society MyPDS Registration:

This form ensures proper registration of your MyPDS account. This account is used for tracking of your involvement in the UCSD Pre-Dental Society. The UCSD Pre-Dental Society does not guarantee tracking of involvement until this account is properly registered.

Registration occurs online, at <https://my.ucsdpds.org>. Please use the "Register" button at the link above to start. You MAY NOT use an email address registered with an ".edu" ending (e.g. @ucsd.edu).

Volunteer Info:

Name:	
Email:	
Phone:	
Signature:	

Registration Verification:

Registration Phrase:	
-------------------------	--

*** Please make sure to register on MyPDS and write down the email you used to register your account.**

Background Check

- You will need to do a DOJ and FBI live scan background check
- Please do your background check at UCSD.
 - Make a live scan appointment by calling UCSD Human Resources at (858)534-9691 or by sending an email to livescan@ucsd.edu. Appointments are available weekdays, 8:30 a.m. to 4 p.m.
 - Take your “Request For Live Scan Service” Form, your background Check Release Form, and a valid photo ID to UCSD Human Resources.
 - 10280 N. Torrey Pines Road Suite 266, La Jolla, CA 92093

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

SECTION 1	<p>Agency Address Set Contributing Agency: UCSD Human Resources Department 10280 N. Torrey Pines Road, Suite 266 La Jolla, CA 92093</p> <p>OCA No. (Agency Identifying No.): 144529</p> <p style="text-align: right;">Mail Code Assigned by DOJ: 07653 Contact: UCSD Human Resources Contact Telephone Number: (858) 534-9691</p> <p style="text-align: right;">ORI (Code Assigned by DOJ): A2004</p>
SECTION 2	<p>TO BE COMPLETED BY REQUESTING DEPARTMENT</p> <p>Department Name: _____ Index No.: _____ Job No.: _____ Hiring Supervisor: _____ E-Mail: _____ Phone: _____ Dept. HR Contact: _____ E-Mail: _____ Phone: _____</p> <p>Type of Application: <input checked="" type="checkbox"/> Check One <input type="checkbox"/> Employment <input type="checkbox"/> Volunteer</p> <p>Job Title or Volunteer Position: _____</p> <p>Level of Service: <input checked="" type="checkbox"/> Check One <input type="checkbox"/> DOJ <input type="checkbox"/> DOJ and FBI</p> <p>If Resubmission, List Original ATI Number: _____</p>
SECTION 3	<p>TO BE COMPLETED BY APPLICANT</p> <p>Name of Applicant: _____ Last First Middle</p> <p>Other Name(s), Alias: _____ Last First Middle</p> <p>Home Address: _____ Street or P.O. Box City, State, and Zip Code</p> <p>Driver License Number: _____ Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Name as it Appears on License: _____ Last First Middle</p> <p>Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____</p> <p>Place of Birth: _____ Social Security Number: _____</p>
SECTION 4	<p>UCSD Human Resources Use Transmitting Agency: UCSD Human Resources</p> <p>Live Scan Transaction Completed By: _____ Date: _____ Name of Operator</p> <p>ATI Number: _____ Amount Billed/Collected: _____</p>

INSTRUCTIONS TO APPLICANT:

- Complete and sign the Release and Request Forms supplied by the UCSD Requesting Department requiring your fingerprints.
- Make a live scan appointment by calling UCSD Human Resources at (858) 534-9691 or by sending an email to livescan@ucsd.edu. Appointments are available weekdays, 8:30 a.m. to 4 p.m.
- Bring your "Request For Live Scan Service" Form, your Background Check Release Form, and a valid photo ID to UCSD Human Resources, Torrey Pines Center South, 10280 N. Torrey Pines Road, Suite 266, San Diego, CA 92093. For directions, you may call (858) 534-9691.
- The UCSD Requesting Department will be responsible for the payment of any rolling and/or processing fees.

UC San Diego
Authorization of Background Investigation

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency such as HireRight, Inc. ("HireRight") and/or the California Department of Justice ("DOJ"), and to the release of such background reports to UC San Diego and its designated representatives and agents, for the purpose of assisting UC San Diego in making a determination as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention or for other lawful employment purposes. I understand that if UC San Diego hires me or contracts for my services, my consent will apply, and UC San Diego may, as allowed by law, obtain additional background reports pertaining to me, without asking for my authorization again, throughout my employment or contract period from HireRight and/or other consumer reporting agencies.

I understand that information contained in my employment or contractor application, or otherwise disclosed by me before or during my employment or contract assignment, if any, may be used for the purpose of obtaining and evaluating background reports on me. I also understand that nothing herein shall be construed as an offer of employment or contract for services.

I hereby authorize all of the following, without limitation, to disclose information about me to the consumer reporting agency and its agents: law enforcement and all other federal, state and local agencies, learning institutions (including public and private schools, colleges and universities), testing agencies, information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and all other individuals and sources with any information about or concerning me. The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate and complete. I agree that this form in original, faxed, photocopied or electronic (including electronically signed) form, will be valid for any background reports that may be requested by or on behalf of UC San Diego.

California, Minnesota or Oklahoma applicants only: Please check this box if you would like to receive (whenever you have such right under the applicable state law) a copy of your background report if one is obtained on you by UC San Diego (applies to HireRight checks only).

Signature: _____ Today's Date: _____

(PLEASE TYPE OR PRINT CLEARLY IN INK)

Full Name: _____ Suffix: JR _____ SR _____ III _____
[Do Not Abbreviate] First Middle Last

Other Names Used (alias, maiden, nickname): _____ DATES USED: _____

Consumers from Spanish speaking countries such as Brazil, Mexico, Puerto Rico, etc., please include **Mother's FULL Maiden Name**
(Utilized as verifying information only): _____

Current Address: _____
Street or P. O. Box City State Zip Code County Date Lived

Former Address: _____
Street or P. O. Box City State Zip Code County Date Lived

Social Security Number: | | | | | | | | | | Full Name on SSN: _____

Driver License Number: _____ State of Issuance: _____ Name on License: _____

Date of Birth (month/day/year)*: ____ / ____ / ____ Gender*: Female _____ Male _____ Are you at least 18 years of age? Yes _____ No _____

- Have you ever been sanctioned or had your license suspended or revoked? Yes _____ No _____
- Are you currently under any investigation or pending charge? Yes _____ No _____
- Have you ever been convicted of a felony or misdemeanor which resulted in imprisonment, probation, or a fine of more than \$500? Yes _____ No _____

*This information will enable us to properly identify you in the event we find adverse information during the course of our background search.

REQUESTING DEPARTMENT: Retain copy for your files. KEEP ONLY IN SECURE FILES and SEPARATELY FROM PERSONNEL RECORDS.

Send Results of Report To: _____ Bill To Index Number: _____

- You must provide a copy of the requested immunizations, TB test and CPR card.
- If you do not have proof of your immunizations, you must do a blood test to confirm your immunizations.
- TB tests:
 - The skin or quantiferon TB tests need to be done annually.
 - If your results are positive for TB due to receiving the BCG vaccine and/or latent TB, you will need to take an X-ray every 4 years and complete the TB questionnaire annually.

UCSD FREE CLINIC PROJECT

VOLUNTEER ANNUAL TUBERCULOSIS SCREENING

Please complete and return as soon as possible to Anne Crane, UCSD Free Clinic Volunteer Coordinator, Mail code 0696.

NAME: _____ DATE _____

_____ Free Medical Clinic Volunteer _____ Free Dental Clinic

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS RECENTLY?	YES	NO
Chronic cough or change in character of cough (more than 2 weeks duration)?		
Bringing up sputum every day for two weeks or more?		
Chronic feeling of fatigue or listlessness (more than 2 weeks duration)?		
Fever (more than 1 week duration)?		
Night sweats?		
Unexplained weight loss (8 pounds or more)?		
Loss of appetite?		
Hoarseness?		
Chest discomfort with cough?		
Coughing up blood?		

If you answered yes to one or more questions, please see your primary care physician immediately. Before returning to clinic you will need to provide a note from your physician regarding any treatment or test results for tuberculosis (e.g., chest x-ray). We want to ensure your health and that of anyone you encounter.

Please contact Sara Hamzeinejad at sara.hamzeinejad@ucsdpds.org if you have any questions.