

Bachelor of Health Science Clinical Observation - Site Form

Agency Name: _____

Address: _____ Phone: _____

_____ Fax: _____

_____ Website: _____

Supervisor Name and Title: _____

Phone: _____ Email: _____

Please check all that apply. The student will:

Be required to fill out a volunteer application.

Complete a required training for volunteering with my organization.

Be required to complete a background check.

Does your agency's insurance policy cover volunteers while at your organizations service sites?

Yes No

As the student's supervisor, you agree to:

Orient students to the agency prior to them beginning their observation (organization mission, history, on-site rules, regulations, safety procedures, and expectations impacting the volunteers' service).

Verify student volunteer hours.

Supervise the student throughout the duration of his/her clinical observation.

Ensure the student's role is one of observer. That is, students are not responsible for providing care, in any form, to patients/clients.

Student Signature

Date

Supervisor Signature

Date