University of Washington School of Medicine
Graduate Medical Education

Updated 5/21/2019

Request to Participate in Medical Volunteer Activities

Please submit form with all fields completed at least two (2) weeks prior to the planned volunteer activity. Incomplete forms will be returned to the program. For questions with the form, please contact Kaitlen Knight in the GME office at kaitlenk@uw.edu. Additional information is also available in the Medical Volunteer Activities Policy.

1. Trainee Name: _____
2. Residency/Fellowship Program: _____
3. R-Level at Time of Activity: _____
4. Physician License Number: _____
5. Will you be prescribing? ☐ Yes, I will be prescribing. ☐ No, I will not be prescribing.
6. Describe the activities to be performed:
   _____
   _____
   _____
   _____
   _____
7. Dates upon which activities will begin _____ and end _____
8. Average number of expected volunteer hours: _____
9. Institution/Site Name: _____
10. Location: _____
    If outside of Washington State, please provide evidence of appropriate licensure.
11. Have you been asked to sign an agreement or a contract? ☐ Yes ☐ No
    If you answered Yes above, please attach a copy of the agreement or contract with your request form.
12. Supervising physician(s): _____
13. Type of supervision available: ☐ Direct Supervision ☐ Indirect Supervision ☐ Oversight
14. Provisions to ensure security of medical records, if applicable:
    _____
    _____
    _____

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Trainee's Certification

I certify that I will comply with all of the following conditions while engaging in this professional volunteer activity:

- I will remain in good standing in my approved training program, as documented by satisfactory evaluations, while participating in professional volunteer activities.
- I agree to be bound by the work hour limits as established in the Institutional Duty Hours Policy.
- I will maintain appropriate licensure for the state/country in which I will be participating in professional volunteer activities.
- I may not engage in professional volunteer activities in which there may be a conflict of interest with my appointment at the University of Washington.
- I understand whether or not professional liability coverage is needed.

_____ _____

Trainee Signature Date

Program Director Approval

_____ _____

Program Director's Signature Date

GME Office Approval

_____ _____

Office of Graduate Medical Education Signature Date