Loss Control & Prevention

Adult Volunteer Waiver Form

Appendix F

Parish/School Information	
Location Name:	Location #:
Location Address:	Telephone:
Volunteer Manager:	Email:
NOTICE TO ADMINISTRATORS/SUPERVISORS: THIS FORM MUST BE COMPLETED BY THE LOCATIONS VOLUNTEER MANAGEMENT AND SIGNED BY THE VOLUNTEER FOR ALL ACTIVITIES SPONSORED BY THE DIOCESE OF SAN JOSE AND ITS SCHOOLS OR PARISHES. *REFER ANY QUESTIONS TO THE LOSS CONTROL & PREVENTION TELEPHONE: 408.983.0237 / FAX: 408.983.0296 / LAVOUN@DSJ.ORG*	

Volunteer Personal Information	
Volunteer Name:	Telephone:
Home Address:	Email:
Volunteer Manager:	Telephone:
Medical Plan Name:	Policy Number:
Medical Plan Address:	Telephone:
Emergency Contact Name:	Telephone:
Emergency Contact Name:	Telephone:

Volunteer Activity Information	
Volunteer Date:	Volunteer Job:
Detailed Description of Volunteer Job DutiesAd:	

Waiver Authorization	
FORM MUST BE COMPLETED IN ALL RESPECTS, SIGNED AND DATED TO AUTHORIZE THE WAIVER.	
I HOLD THE PARISH/SCHOOL AND DIOCESE OF SAN JOSE HARMLESS FROM ANY CLAIM OF INJURY, SICKNESS, ILLNESS OR DAMAGE THAT I MAY SUFFER OR SUSTAIN DURING THE ACTIVITY LISTED ABOVE, WITH EXCEPTION TO INJURY OF DAMAGES ARISING OUT OF THE SOLE NEGLIGENCE OF THE PARISH/SCHOOL OR DIOCESE OF SAN JOSE. *I ATTEST THAT I AM IS PHYSICALLY FIT TO PARTICIPATE IN THIS EVENT.* *IN THE EVENT I BECOME ILL OR INJURED, I DO HEREBY CONSENT TO WHATEVER X-RAY, EXAMINATION, MEDICAL OR TREATMENT AND HOSPITAL CARE ARE CONSIDERED NECESSARY IN THE BEST JUDGEMENT OF THE ATTENDING PHYSICAIN AND PERFORMED BY OR UNDER THE SUPERVISOIN OF A MEMBER OF THE MEDICAL STAFF OF THE HOSPITAL FACILITY PROVIDING THE TREATMENT.* *I AM NOT AWARE OF ANY MEDICAL CONDITION WHICH WOULD RENDER IT INAPPROPRIATE FOR ME TO PARTICIPATE IN ANY SUCH ACTIVITY.*	
Volunteer Signature:	Date Signed:

Loss Control & Prevention Use Only	
Received By:	Date Received:

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The Chancery ● 1150 North First Street ● Suite 100 ● San Jose, California 95112-4966
(408) 983-0237 ● www.dsj.org ● Fax (408) 983-0296