

CHP COVER SHEET

This form must be submitted **ALONG WITH**

- HIPAA for Researchers training certificate
- UF Confidentiality statement (printed, signed)
- Patient contact certification (for students with patient contact)

Last Name	
First Name	
UFID (xxxx-xxxx)	
Gatorlink ID/username (xxxx@ufl.edu)	
Have you completed ALL the “reference” name/relationship/phone information on the bottom of the Volunteer Form in the “supervisor” section? WILL ONLY BE PROCESSED IF YOU ANSWER “YES”	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the supervisor signed the bottom of the volunteer form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of PPHP folder(s) to which you should be granted access (Write “none” if no access requested)	
Desired END DATE for access	
Is a PPHP (paper) mailbox requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the volunteer have PATIENT CONTACT? (If yes, please make sure patient contact certification is attached)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor’s signature and date	

Date submitted to CHP office: _____