



VOLUNTEER REGISTRATION FORM

The undersigned person desires to provide volunteer services to The Graduate School and University Center of The City University of New York.

Name (please print): _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. (please include code): (_____) - _____

E-Mail Address: _____

The following conditions apply to such appointment:

1. The undersigned person waives the right to any salary or any other form of compensation, which may result under these terms of any otherwise possible applicable collective negotiating agreement, action of The City University of Trustees, or provision or law.
2. The undersigned person further waives any right he or she may have to any membership in or benefit from any health, or welfare plan or retirement system or consideration for future employment on the basis of service pursuant to this appointment, or credit for service pursuant to this appointment, or any other right, privilege, or benefit to which he or she may otherwise be entitled by virtue of this appointment, under the terms of any applicable collective negotiating agreement, action of The City University of Board of Trustees, or provisions of law.
3. The undersigned acknowledges and agrees that the above-specified appointment is subject to approval by The City University Board of Trustees and sufficient student registration.
4. The undersigned person hereby accepts the appointment for the period of _____ to _____ to the title of Volunteer at the Graduate Center. (The duties and schedule are listed on the reverse side of this form.)

Name (please print)

Signature Date

Graduate Center Personnel Director

Date

The Executive Officer (EO)/Head of Office/Supervisor must complete this section.

Class(es)/Assignment: _____

Schedule (include days of the week and hours): _____

EO/Head of Office/Supervisor Initials

Volunteer's Initials

Emergency Contact Information: *To be completed by the Volunteer at orientation in the Office of Human Resources.*

Emergency Contact Name: _____ Relationship _____

Address: _____

E-mail: _____

Day Phone: _____

Evening Phone: _____

Doctor's Name: _____

Phone No: _____

List any medications you are allergic to, any Chronic or other Conditions: _____

In the event that no one can be reached by phone or E-mail, what do you wish the Graduate Center to do if you become ill? _____

We recommend that this information be shared with the EO/Head of Office/Supervisor. May we share it?		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Volunteer's Initials <input type="checkbox"/>

PLEASE CONTACT THE OFFICE OF HUMAN RESOURCES IF THE ABOVE INFORMATION CHANGES.