City of Riverside
Human Resources Department
INTERN/VOLUNTEER CONFIDENTIALITY AGREEMENT

I understand that as an intern/volunteer of the City of Riverside, during the course of my work assignments, I may learn certain facts about an employee, a potential employee (applicant), and/or City resident that are highly personal and of a confidential nature (i.e., health information, Social Security number, phone, etc.); that could potentially violate their personal privacy.

I agree to protect employee confidential information, potential employee (applicant) confidential information and/or City resident confidential information. I agree not to use, copy, make notes regarding, remove, release or disclose confidential information unless approved by my department head or division manager.

I also understand that confidential information is to be protected in every form:
written records and correspondence, oral communications, and computer programs/applications. I agree to properly secure hard copies (documents, printed material) of confidential information in my work area. I agree to take steps to properly secure confidential information on my computer or use a password-protected screensaver to prevent access by unauthorized users. I will not disclose my system(s) password(s) to anyone without the express written permission of my department head; I will not post my password(s) in an accessible location and will refrain from performing any tasks using another's password(s).

I acknowledge my responsibility to review and comply with all City of Riverside guidelines, policies, and State/Federal regulations pertaining to privacy and security of confidential information.

I understand that unauthorized access to and/or disclosure of confidential information both during and after my time as an intern or volunteer, in addition to theft, destruction, alteration or sabotage of such information are grounds for immediate disciplinary action, up to and including termination of employment.

Disciplinary Action for Non-Compliance
Violation of this policy is cause for immediate disciplinary action, up to and including termination of internship or volunteer assignment.

Signature: _____ Intern: ☐ Volunteer: ☐

Print name: _____

Date: _____ Department/Division_____

City of Riverside
Human Resources Department/
Workers' Compensation Division

ACCIDENT/INJURY
AUTHORIZATION FORM TO CONSENT TO THE MEDICAL/SURGICAL TREATMENT OF A MINOR

Pursuant to California Family Code Sections 6902 and 6910, I the undersigned, parent and or

legal guardian of _____ whose date of birth is _____ do hereby authorize medical and or surgical treatment by a State of California licensed Medical Doctor (M.D.) and/or a State of California licensed Hospital and/or a licensed Hospital Emergency Room and/or a Private Practice Office operated by a State of California licensed Medical Doctor (M.D.), duly certified and licensed and/or their representatives as agent(s) for the undersigned to consent to any x-ray, laboratory, anesthetics, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of a licensed Medical Doctor (M.D.) per the provisions of the Medical Practice Act and who is on the staff of the accredited hospital, whether such diagnosis or treatment is rendered at the office of the treating physician or at an accredited hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority, consent and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of their Medical and Surgical judgment may deem advisable.

In addition, you are authorized to release and/or to receive any and all medical records and/or related medical information pertaining to and/or aiding in the treatment rendered the (Minor) named above with regards to the (Minor/Minor's) Industrial Accident/Injury.

Dated: _____ Signed:_____
(Parent or Legal Guardian)

Dated: _____ Signed:_____
(Witness Signature)

In case of emergency, please notify:

Name:_____ Relationship _____

Address:_____ City_____ Zip _____

Telephone:_____

City of Riverside
Human Resources Department
Workers' Compensation Division

INTERN/VOLUNTEER ACKNOWLEDGEMENT OF RECEIPT OF CITY OF RIVERSIDE WORKERS' COMPENSATION MEDICAL PROVIDER NETWORK INFORMATION

I acknowledge that I have received information regarding my employer's use of Medical Provider Network for Workers' Compensation claims. The information given to me includes:

1. **Medical Provider Network Official Notification**
2. **City of Riverside Medical Provider Network**
3. **Pre-Designation of Physician Form**

_____ _____

Intern/Volunteer's Name (Print) Intern/Volunteer's Department

_____ _____

Intern/Volunteer's Signature Today's Date

City of Riverside
Human Resources Department
Workers' Compensation Division

City of Arts & Innovation

INTERN/VOLUNTEER PREDESIGNATION OF PERSONAL PHYSICIAN FOR ON THE JOB INJURY (WORKERS' COMPENSATION)

In the event you sustain an injury or illness related to your internship or volunteering, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
- **prior to the injury** your doctor agrees to treat you for work injuries or illnesses;
- **prior to the injury** you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN
Intern/Volunteer: Complete this section.

If I have a work-related injury or illness, I, _____ (name of intern/volunteer), choose to be treated by:

_____
(name of doctor)(M.D., D.O., or medical group)
_____ (street address, city, state, ZIP)
_____ (telephone number)
Intern/Volunteer Name (please print):
_____

Intern/Volunteer Address:
_____

Name of Insurance Company, Plan, or Fund providing health coverage for non-occupational injuries or illnesses:

Intern/Volunteer's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

Physician's Office Address: _____

Mailing address if different: _____

Phone Number: _____ Fax: _____

Physician Tax ID Number: _____

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
DWC FORM 9783 (7/2014)