

REQUEST FOR VOLUNTARY ATTENDANCE

I, the undersigned:

NAME		LAST NAME	
PLACE AND DATE OF BIRTH		ITALIAN ID CODE/PASSPORT NUMBER	
RESIDENCE IN		STREET NAME AND NUMBER	ZIP CODE
PHONE NUMBER	MOBILE PHONE NUMBER	E-MAIL	
QUALIFICATION/DEGREE			

REQUEST TO ATTEND

FOR THE PERIODO FROM _____ TO _____

THE FONDAZIONE'S DEPARTMENT

FOR THE FOLLOWING REASONS

To this end aware of the penal sanctions, in the case of untrue statements, referred to in Article 76 Presidential Decree 445/2000

I DECLARE:

1. That I have read the current procedure on voluntary attendance, that I accept it in full and without reservation, and in particular that I am aware that voluntary attendance does not constitute an employment relationship and does not entitle me to any remuneration
2. Not to be in the cases of exclusion indicated in Article 2 of the procedure.
3. That I know and accept the contents of the Code of Ethics and the Model of Organization, Management and Control adopted by Fondazione (available at the website: www.policlinicogemelli.it) and undertake to comply with all its provisions. In case of violation of even one of the provisions contained in the Code of Ethics, Fondazione will have the right to terminate attendance.
4. To be aware that authorization for attendance may be issued only upon delivery of:
 - Insurance policy in Italian or English for permanent disability and death resulting from accidents and illnesses contracted during voluntary attendance
 - Proof of payment made in accordance with Article 4.1, paragraph 5, of the procedure
 - Curriculum vitae
 - Copy of an identification document
 - Residence Permit for Study Purposes (for non-EU citizens only)
 - Authorization from the employer (for employees)

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Request that any communication regarding this application be forwarded to the following address (if different from the above address):

Pursuant to EU Regulation 2016/679, the undersigned declares that he/she is informed that his/her personal data will be processed by Fondazione Policlinico Universitario Agostino Gemelli IRCCS only for institutional purposes related to voluntary attendance and that the same will not be communicated to third parties, except in the case in which the communication is required to fulfill a legal obligation and/or an order of the Public Authority.

DATE

SIGNATURE

Part reserved for prior consent to attendance

You consent to the attendance of Dr. _____
in departments belonging to the O.U. _____

For the purpose of a risk exposure assessment, pursuant to Legislative Decree 81/2008, it is stated that attendance will take place at:

- Inpatient Department/D.H. _____
- Outpatient clinic _____
- Laboratory _____
- Surgery room _____
- Administration Offices _____
- Other (please specify) _____

DATE

SIGNATURE OF THE PERSON IN CHARGE U.O.C. (MULTISPECIALTY DEPARTMENT)

DATE

ENDORSEMENT OF THE HEALTHCARE DIRECTOR