SHORT-TERM VISIT APPLICATION

- **Short-Term Visit Form** – please complete.
- **Volunteer Election of Workers' Compensation Coverage** – please complete and sign the bottom of the form
- **Emergency Contact Form** – please complete.
- **Waiver if Liability, Assumption of Risk, and Indemnity Agreement** – please read and sign the form.
- **Laboratory Safety Information** – if you will be working in a lab, you *must* complete the laboratory safety training

Please return the completed forms to 277K ENG VI *before your effective date*

UNIVERSITY OF CALIFORNIA, LOS ANGELES (UCLA)
COMPUTER SCIENCE DEPARTMENT

SHORT-TERM VISIT FORM

Last Name: _____ **First Name:** _____

Permanent Address: _____

_____

Home Institution: _____

Research Title: _____ **Degree:** _____ **Non-degree:** _____

Duration of Visit: _____ to _____
(Begin Date) (End Date)

Professor Name: _____ **Phone Number:** _____

Work Location: _____

Nature of Visit:

U.S. Current Address:

Address: _____

_____

Phone Number: _____

Email: _____

Key Issued: _____ to _____
(Date Issued) (Date Returned)

UNIVERSITY OF CALIFORNIA, LOS ANGELES (UCLA)
VOLUNTEER ELECTION OF WORKERS' COMPENSATION COVERAGE

(For use for persons not employed by UCLA who are providing volunteer services for UCLA benefit)

(Please print or type)

NAME OF VOLUNTEER: _____ SOCIAL SECURITY NO.: ____-____-____

DATE OF BIRTH: _____ SEX: _____ HOME PHONE: ( ) _____

HOME ADDRESS:

_____

UCLA SPONSORED PROGRAM/EVENT/ACTIVITY IN WHICH SERVICE WILL BE PROVIDED: _____

UCLA DEPARTMENT FOR WHICH VOLUNTEER SERVICES WILL BE PROVIDED: _____

NAME OF UCLA EMPLOYEE SUPERVISING VOLUNTEER: _____ SUPERVISOR'S PHONE _____

Starting Date of Volunteer Service: _____ Ending Date of Volunteer Service: _____

ELECTION OF WORKERS' COMPENSATION REMEDY: As a condition of my participation in UCLA volunteer service and in consideration for my use of UCLA facilities and equipment, I, the above named volunteer, hereby understand and agree that in the event I am injured or contract an illness or disease either during my UCLA volunteer service, or subsequent thereto as a result of such service, that **I am hereby electing to be covered under the University of California's Self Insured Workers' Compensation Program as** a volunteer for the University of California, Los Angeles Campus, UCLA, and that the benefits provided by the Labor Code of the State of California shall be **MY SOLE AND EXCLUSIVE REMEDY FOR ANY AND ALL SUCH INJURIES, ILLNESSES OR DISEASES.** This election of remedy shall be binding on me, my heirs, personal representatives, and assigns.

WAIVER, RELEASE & INDEMNIFICATION: In consideration of my use of UCLA facilities and of equipment and of my coverage under the University's Self Insured Worker's Compensation Program, I, the above named Volunteer, hereby for myself, my heirs, personal representatives, insurers and assigns **do hereby voluntarily waive, release, discharge, and covenant not to sue The Regents of the University of California (Regents), its officers, agents, volunteers and employees** (herein referred to as University) for any and all actions, claims, or causes of action for bodily injury, personal injury, property damage, or wrongful death occurring or arising out of the course and scope of my volunteer service, whether the same shall arise by contract, the negligence of the University, or otherwise. **IT IS MY INTENTION BY THIS INSTRUMENT TO EXEMPT AND RELIEVE THE UNIVERSITY FROM ANY AND ALL LIABILITY TO ME, MY HEIRS, PERSONAL REPRESENTATIVES, INSURERS OR ASSIGNS FOR BODILY INJURY, PROPERTY DAMAGE, AND WRONGFUL DEATH CAUSED BY NEGLIGENCE, INCLUDING THE NEGLIGENCE OF THE UNIVERSITY to the fullest extent permitted by law.**

I, the above named Volunteer, for myself, my heirs, personal representatives, insurers and assigns do hereby agree, that in the event any claim, action, or lawsuit for bodily injury, property damage, or wrongful death arising out of my volunteer services shall be prosecuted against the University, to defend, indemnify and hold the University harmless from and against any and all such claims, actions, or lawsuits by whomever or wherever made or presented, including, but not limited to, attorney's fees, expenses and court costs, except for such claims, actions or lawsuits as result from the willful misconduct of employees of the Regents.

I, the above named Volunteer, hereby expressly waive all rights under Section 1542 of the *Civil Code of California* which states that a "general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

SEVERABILITY: If any portion of this Election of Workers' Compensation Remedy, Waiver, Release and/or indemnification is held invalid, it is agreed that the balance shall continue if full legal force and effect.

REPORTING OF INJURIES/ILLNESSES AND MEDICAL TREATMENT: I hereby agree to report all injuries or illnesses received in the scope of UCLA volunteer service to the UCLA department for which I am providing volunteer service and to the Office of Risk and Insurance Management (310) 794-6948, FAX (310) 794-6957, 10920 Wilshire Blvd, Suite 860 Los Angeles, CA 90024 immediately. Volunteers injured on the UCLA Campus are ONLY authorized to be treated at the UCLA Occupational Health Facility.

I, the above named volunteer, have read and understand the above "Election of Workers' Comp. remedy," the "Waiver, Release and Indemnification," and the waiver of Civil Code Section 1542 rights, and agree to all of them.

Signature of Volunteer: _____ Date: _____

Signature of Parent/Legal Guardian (if Volunteer is a minor): _____ Date: _____

Signature of University Supervisor: _____ Date: _____

UCLA

FACTS ABOUT WORKERS' COMPENSATION

The content of this pamphlet has been approved by the Administrative Director of the Division of Workers' Compensation.

The information in this pamphlet is available in Spanish. To obtain a copy, please call: UCLA Workers' Compensation 310 794-6948.
La información en este folleto esta traducido al español. Para conseguir una copia, favor de llamar: UCLA Workers' Compensation 310 794-6948.

WHAT IT IS
Since 1913, California Workers' Compensation law has guaranteed prompt, automatic benefits to workers who become injured or ill because of their jobs. It is mandatory no-fault insurance, paid for entirely by your employer, that pays your medical expenses and helps replace lost wages when you are disabled from work because of a work-related injury or illness.

WHO IT COVERS
All UCLA employees and registered volunteers are covered for Workers' Compensation.

WHAT IT COVERS
Almost any job-related injury or illness is covered. Simple first-aid incidents and serious accidents are both covered. Physical and psychological injuries incurred by victims of violent workplace crime are covered. There are a few injuries that may not be covered depending on how they occur; for instance, injuries that result from voluntary, off-duty recreational, social, or athletic activities are not covered. If you wish more information on the types of injuries not covered by workers' compensation, contact the UCLA Workers' Compensation Office at 310 794-6948.

HOW TO REPORT AN INJURY
Immediately report to your supervisor any injury, no matter how slight. You can also report your injury to UCLA WC at 310 794-6948. If your injury is more than a simple first-aid case, your Human Resource office will give you a Claim Form (DWC 1), with instructions to complete the form and return it. You can also obtain a claim form on the UCLA WC web site at: http://www.oirm.ucla.edu/DWCForm1.pdf or you can call UCLA WC at 310 794-6948 and request that a claim form be mailed to you.

State law requires employers to authorize medical treatment within one working day of receiving the completed claim form from you. If you delay reporting your injury or delay completing the claim form, it may result in a delay in receiving benefits; and too long a delay may even jeopardize your right to obtain benefits altogether.

Work Injury Reporting Hotline 877 682-7778

Supervisors, managers, and staff can now call a toll-free number to report any injury. This service is available 24 hours a day, seven days a week. Employees should continue to promptly inform their supervisor if they have been injured, and, in an emergency, urgent medical care should be sought immediately.

NON-DISCRIMINATION
It is illegal for your employer to fire you or in any way discriminate against you because you file a claim, intend to file a claim, settle a claim, testify or intend to testify for another injured worker. If it is found that UCLA discriminated, UCLA may be ordered to reinstate you to your job, reimburse you for lost wages and employment benefits, and pay increased workers' compensation benefits, costs and expenses up to maximum amounts set by state law.

EMERGENCY PHONE NUMBERS
Doctor: Occupational Health Facility 310-825-6771

Fire:
Police:
Hospital:
Ambulance:

911 (cell phone 310 825-1491)

EMPLOYER REPRESENTATIVE
Insurance & Risk Manage
Workers Compensation
10920 Wilshire Blvd. #860
Los Angeles, CA 90024-1352
Tel: 310-794-6948 (UCLA is self-insured)

CLAIMS ADMINISTERED BY:
Sedgwick Claims Management Services
P.O. Box 14533
Lexington, KY 40512-4533
Tel: 310-253-7500

DWC INFO & ASSISTANCE OFFICE
4720 Lincoln Blvd
Marina del Rey, CA 93117
Tel: 310-482-3858

IF YOU HAVE OTHER QUESTIONS

Please see the telephone numbers above. You can contact UCLA WC at 310 794-6948 or Sedgwick CMS at 310-253-7500. You can also contact an Information and Assistance officer at the State Division of Workers' Compensation (DWC) at 310-482-3858 Information and Assistance officers provide continuing information on rights, benefits, and obligations. They assist in the prompt resolution of misunderstandings and disputes without formal proceedings to the end that full and timely benefits are furnished. Their services are available to you at no cost. You can hear recorded information and a list of local offices by calling 800-736-7401.

You can also check the local listing in the phone book under State Government Offices/Industrial Relations/Workers' Compensation. You may also go to the DWC web site at www.dwc.ca.gov, and link to Workers' Compensation. There you will find informational pamphlets approved by the Division of Workers' Compensation and distributed by the Information and Assistance officers.

BENEFITS

Medical Care
Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by your doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly, so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

How to Obtain Medical Care

FIRST AID:
Seek first-aid immediately.

EMERGENCY CARE:
Get help immediately. See the emergency telephone numbers in this pamphlet, which should also be posted in your workplace. Call an ambulance or go to the nearest emergency room.

ACUTE AND FOLLOW-UP CARE:

A. If you predesignated your personal M.D. or D.O. (see form in this pamphlet):
Contact your physician as soon as possible and make arrangements for treatment.

B. If you did not predesignate your personal M.D. or D.O.: Call UCLA WC at 310-794 6948 as soon as possible to help you make arrangements for treatment.

Temporary Disability Payments
If you are disabled for more than three (3) calendar days, temporary disability payments will partially replace your lost wages. The first three calendar days are not paid unless you are disabled for more than 14 days, or are hospitalized overnight. You should receive your first payment within two weeks of reporting your injury. Every two weeks after that, you will receive another payment.

Temporary Disability pays two-thirds of your average wage, subject to minimum and maximum amounts set by state law. The payments are tax-free and there are no deductions.

TD payments stop when your doctor says you can return to work, or your condition has become Permanent and Stationary (your medical recovery has reached maximum foreseeable improvement). Also, for injuries occurring on or after April 19, 2004, TD payments stop after 104 payable weeks within two years from the date of the first TD payment; or after 240 payable weeks within five years from the date of injury for specific long-term conditions such as amputations, severe burns, and certain chronic diseases.

Permanent Disability Payments
If a doctor says your injury or illness will always leave you somewhat limited in your ability to work, you may be eligible for permanent disability payments. The amount will depend on the type of injury, your age, occupation, date of injury, and how much of the permanent disability was caused by the work injury. There are minimum and maximum amounts set by state law. Payments are made at a regular rate and are spread out over a fixed number of weeks until the total amount has been paid. If you received temporary disability payments, the first permanent disability payment is due within 14 days after the TD payments stopped. If you did not receive TD payments (many people with permanent disability keep working), the first permanent disability payment is due within 14 days after your doctor says your condition is permanent and stationary (your medical recovery has reached maximum foreseeable improvement). Subsequent payments are made every 14 days until the total amount is paid.

Death Benefits
If the injury or illness causes death, payments may be made to relatives or household members who are financially dependent on you. The amount is set by state law and depends on the number of your financial dependents. Payments are made at the same rate as temporary disability. A burial allowance is also provided.

Supplemental Job Displacement Benefits
If you have permanent disability and you do not return to work within 60 days after your temporary disability ends, and the University does not offer modified or alternative work, you may qualify for a non-transferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

If Benefits Are Denied
You have the right to disagree with any decision affecting your claim. Call your claims administrator first to see if you can resolve any disagreement. For free assistance, you can contact an Information and Assistance officer at the Division of Workers' Compensation (see the section of this pamphlet captioned "If You Have Other Questions"). You can also file with the Workers' Compensation Appeals Board (WCAB). There are deadlines for filing the necessary WCAB paperwork, so you should not delay. You can also consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of your benefits. For names of W/C attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

YOUR TREATING PHYSICIAN

Quality medical care is crucial to making the best recovery from your work injury or illness.

Primary Treating Physician (PTP)
Your primary treating physician (PTP) is the doctor with overall responsibility for treating your work injury or illness and for coordinating care with other providers. The PTP decides what type of medical care you need; whether there are temporary or permanent medical limitations or restrictions on your ability to perform work; and when you are able to return to work.

If the injury results in some degree of permanent disability, the PTP will measure the disability and report the findings to your claims administrator. The PTP will also report whether you will need medical care in the future. As part of your Workers' Compensation benefits, the University will provide you with a PTP.

Personal Physician (M.D. or D.O.)
If you have a personal M.D. or D.O. and you wish to designate this physician to be your PTP, you must do so in writing before the injury occurs. In addition, before the injury occurs, the physician must agree to treat you for a work related injury or illness.

One-Time Right to Change PTP
You have the right to change your PTP one time. You can request this change at any time.

Change of PTP: First 30 Days
If you make your request to change PTP during the first 30 days after reporting your injury, you can change to your personal chiropractor or acupuncturist if you have predesignated this physician.

Change of PTP: After 30 Days
If you have not already used your one-time change of PTP, then thirty (30) days after reporting your injury, you may change to the PTP of your own choice. This can be your personal M.D. or D.O., your personal chiropractor, personal acupuncturist, or any physician of your choice within a reasonable geographic area.

Medical Provider Network (MPN)
Employers may offer an Medical Provider Network (MPN), which is a selected network of health care providers to provide treatment to workers injured on the job. If the employer is using an MPN, a MPN notice is required to be posted in the worksite to explain how to use an MPN. **UCLA is not using an MPN**.

WORKERS' COMPENSATION FRAUD IS A FELONY
Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PHYSICIAN PREDESIGNATION FORM

In the event you sustain an injury/illness related to your employment, you may be treated for such injury/illn3ess by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.), medical group, chiropractor (D.C.) or acupuncturist (L.A.C.) if:

Your personal medical physician (M.D. or D.O.) chiropractor (D.C.) or acupuncturist (L.A.C.)

- Is your regular treatment provider
- Has directed your treatment in the past
- Retains your treatment records and history
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses
- Prior to the injury you give your employer the name and address of your personal physician in writing before the injury, then
- You can treat with your personal M.D. or D.O. immediately after the injury.
- You can change to your personal D.C. or L.A.C. if you exercise your right to one change of treating physician.

Your personal M.D. or D.O. must agree to treat you for work injuries or illnesses before one occurs.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) **If I have a work-related injury or illness**,

I choose to be treated by (**Name** of doctor M.D., D.O., Medical Group, D.C. or L.A.C.):

Street address, city, state, ZIP:

_____

Telephone number: _____

Employee Name (please print):_____

Employee's Address: _____

Employee's Signature_____ Employee ID#_____ Date:_____

Physician: I agree to this Predesignation:

Signature: _____Date:_____

The physician is not required to sign this form, however, if the physician or designated employee of the physician 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 **Note to Employee:** Unless an employee agrees, neither the employer nor the claims administrator shall contact your personal physician to confirm a Predesignation (CCR9780.1 (f). If your physician did not sign above, other documentation that they agreed to be predesignated prior to the injury will be required. If you agree that after receiving this form your employer or claims administrator may contact your physician to confirm the predesignation, sign below.

Employee's Signature_____ Employee ID#_____ _____Date: _____

Note to Physician: California Workers' Compensation medical services are subject to preauthorization of non-emergency services; utilization review; reporting requirements; and the California Official Medical Fee Schedule.

Computer Science Department
School of Engineering and Applied Science
University of California, Los Angeles

To: All Computer Science Personnel

In case of emergency, contact

_____
Name

_____
Address (Street, City, State, and Zip Code)

_____
Telephone Number Relationship

2nd contact person, if the above not available

_____
Name

_____
Address (Street, City, State, and Zip Code)

_____
Telephone Number Relationship

Signature: _____

Printed Name: _____
Date: _____

Privacy Notification

The State of California Information Practices Act of 1977 requires the University to provide the following information to individuals who are asked to supply information about themselves:

The principal purpose of requesting the information on this form is to provide emergency information. University Policy authorizes maintenance of this information.

Furnishing the information requested on this form is voluntary. There is no penalty for not completing the form. Information furnished on this form will be transmitted to the state and federal government if required by law. Individuals have the right of access to this record as it pertains to themselves.

Participant's name: Name

Please Print

UNIVERSITY OF CALIFORNIA, UCLA

Visiting Laboratory or Academic Area for Educational Purposes

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in Description of Class or Activity including date(s)

hereinafter called "The Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims including the negligence of The Regents of the University of California, its officers, employees and agents,** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Assumption of Risks: Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby **assert that my participation is voluntary and that I knowingly assume all such risks.**

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Participant's Age (if minor) _____

UCLA Computer Science Department

Key Checkout Form

Last Name _____ First Name _____ Professor Signature _____

UID#:_____

Title: _____

Email:_____

Home Dept.:_____

$20.00 Deposit for BH swipe cards/keys (check, cash or money order)

Deposit is waived for Bruin card access to EVI building

**Deposits will be returned when key(s) is/are returned. **

Certificate of Lab safety training must be provided

- I certify that I have completed the Laboratory Safety Fundamentals Online Training
  Date:_____
  Class Enrollment and Certification link: https://worksafe.ucla.edu
- I will not duplicate the keys/swipe card or loan them to anyone else.
- I am responsible for keeping the room secure, which includes locking the door each time I leave.
- I will report and problems, malfunctions, vandalism, and/or unauthorized use to the key manager (Mildri Lopez-Duarte in 277M, ENGR VI), the MSO, or the Department Chair.
- If I lose my key/swipe card, the department will not refund my deposit.
- I will take care of any equipment located in any of the offices or labs for which I have keys.

Signature: _____ Date:_____

FOR ADMINISTRATIVE OFFICE USE ONLY					
Date Issued	**Room #**	**Key #**	**Desk #**	**Space Committee Signature**	**Key Return Date**

Date of Deposit	Deposit Amount	Deposit Return Date