Diocese of San Jose

RISK & INSURANCE MANAGEMENT

Activity Waiver Form

General Liability (for all Volunteers)

Parish/School Information	
Location Name: **Saint Joseph Parish Mountain View or School.**	**Location #:**
Location Address: **Church, 582 Hope Street, Mtn.View CA 94041 or** **School, 1120 Miramonte Ave. Mtn.View CA 94040**	Telephone **Church (650) 967-3831 or** Telephone **School: (650) 967-1839**
Ministry: Contact Name:	Telephone:
NOTICE TO ADMINISTRATORS/SUPERVISORS: THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE RISK & MANAGEMENT DEPARTMENT WHEN A VOLUNTEER PARTICIPATESIN AN ACTIVITY LOCATED ON DIOCESAN PROPERTY. *MAIL TO: 1150 NORTH 1ST STREET, SUITE 100, SAN JOSE CA 95112-4966*	

Volunteer Personal Information	
Volunteer Name:	Telephone:
Home Address:	
Supervisor Name: **Depending on activities, any staff employees of sjmv**	Telephone: **see above**
Medical Plan Name:	Policy Number:
Medical Plan Address:	Telephone:
Emergency Contact Name:	Telephone:
Emergency Contact Name:	Telephone:

Activity Information	
Date of Activity(*M/D/Y to M/D/Y*):	Name of Activity: **Any held at St. Joseph MV Parish or School**
Description of Activity: **Any, held at St. Joseph MV Parish or School**	

Waiver Authorization	
FORM MUST BE COMPLETED IN ALL RESPECTS, SIGNED AND DATED TO AUTHORIZE THE WAIVER.	
I HOLD THE PARISH AND DIOCESE OF SAN JOSE HARMLESS FROM ANY CLAIM OF INJURY, SICKNESS, ILLNESS OR DAMAGE THAT I MAY SUFFER OR SUSTAIN DURING THE ACTIVITY LISTED ABOVE, WITH EXCEPTION TO INJURY OF DAMAGES ARISING OUT OF THE SOLE NEGLIGENCE OF THE PARISH OR DIOCESE OF SAN JOSE. *I UNDERSTAND VOLUNTEERS ARE NOTCOVERED BY THE WORKERS COMPENSATION INSURANCE CARRIED BY THE DIOCESE OF SAN JOSE.* *IN THE EVENT I AM INJURED, BECOME ILL AND REQUIRED EMERGENCY MEDICAL ATTENTION, ANY RESULTING HOSPITAL, MEDICAL OR RELATED COSTS AND EXPENSES WILL BE PAID BY THE MEDICAL INSURANCE OR BENEFITS PLAN OF MINE OR MY SPOUSE, OR PARENT.* *I HAVE INDICATED ABOVE THE MEDICAL INSURANCE PLAN THAT WOULD COVER ANY HOSPITAL, MECICAL AND RELATED COSTS AND EXPENSES IN THE EVENT OF ILLNESS, SICKNESS OR ACCIDENT OF AN EMERGENCY NATURE.* *I AM NOT AWARE OF ANY MEDICAL CONDITION WHICH WOULD RENDER IT INAPPROPRIATE FOR MY CHILD TO PARTICIPATE IN ANY SUCH ACTIVITY.* *I HERBY GIVE PERMISSION OT THE PHYSICIA SELELCTED BY PARISH AND DIOCESE OF SAN JOSE PERSONNEL THEN PRESENT TO RENDER MEDICALTREATMENT DEEMED NECESSARY AND APPROPRIATED BY THE PHYSICIAN.*	
Volunteer Signature:	Date Signed:

Internal Use Only	
Waiver Received By:	Date Received: