

SAN GABRIEL UNIFIED SCHOOL DISTRICT
SAN GABRIEL, CALIFORNIA

DATE: _____

TO: Designated Volunteer

FROM: Business Services Department

SUBJECT: WORKERS' COMPENSATION COVERAGE FOR VOLUNTEERS

This is to advise you that the San Gabriel Unified School District has adopted a Board Resolution to cover authorized volunteers for the purpose of Workers' Compensation Insurance. Workers' Compensation benefits will be provided in accordance with the California Labor Code for any injury or illness sustained while engaged in the services as a _____ at _____.
(Description of Job) (Name of School)

Should you be injured while serving in this capacity, and therefore covered under our Workers' Compensation Self-Funded Program, we need to advise you that you would not be eligible to file any civil claim, action or proceeding.

By signing this document, you acknowledge that Workers' Compensation benefits will be the sole remedy and agree to waive any civil liability.

Name _____ Signature _____
(Please Print)

Approved _____ Date _____
(Principal's Signature)

Approved _____ Denied _____ Date: _____
(Asst. Superintendent, Business Services will make determination and sign)