



# spot skin cancer

## American Academy of Dermatology SPOT Skin Cancer™ Screening Volunteer Attestation Form

\*\*\* VERY IMPORTANT! \*\*\*

**Please have all screening volunteers print and sign their names on the back of this document.  
Return this document along with the pink copies of the screening form and the participating volunteers form,  
in the self-addressed envelope to the Academy. Thank you!**

**Date of Screening Opportunity** \_\_\_\_\_ **City, State** \_\_\_\_\_

Thank you for agreeing to participate in the American Academy of Dermatology (Academy or AAD) volunteer opportunity listed above. Please indicate your acceptance and understanding of and willingness to comply with each of the statements below as they relate to your involvement in this opportunity. If you have any questions regarding your ability to provide this attestation, please contact [screenings@aad.org](mailto:screenings@aad.org).

- All SPOT Skin Cancer™ screenings are to be provided free of charge; this is a volunteer opportunity whereby my participation in this event, including time and expenses, are not compensated or reimbursed.
- Except in the case of emergencies, treatment should not be provided at the time of screening even if the screening is held in a private medical office or other health care facility. **NOTE: using free screenings as an inducement for patients to use your medical services may violate federal law if the patient is a federal health plan beneficiary.**
- The Academy does not provide medical malpractice liability insurance coverage for its members, including those who volunteer for free screening programs. Each participating doctor should be aware of the need to obtain advance confirmation, from his/her malpractice carrier or other appropriate sources, that his/her activities in connection with a skin cancer screening program will be covered by adequate liability insurance.
- The Academy is not responsible for any actions of the volunteer physician or practice conducting the screenings (before, during, or after).
- It is imperative that the forms are completed in their entirety, (beginning with the state, zip code and date).
- If I appear in a photograph or a video during a skin cancer screening, taken by the AAD and/or collaborating organization, I give the AAD and/or collaborating organization permission to use my image in print, on film or video and on the AAD website for purposes consistent with AAD's charitable and educational mission. I understand I will not be compensated for any such uses of my image or my involvement in this volunteer opportunity generally.
- After the screening, if a suspicious lesion is found, it is imperative that the screening physician inform the participant of the importance of a follow-up examination and that it is the participant's responsibility to arrange for such follow-up examination with a dermatologist of choice. After explaining the importance of the follow-up exam, the physician's signature is required and the participant is required to initial the bottom of the form.
- After the screening, you should provide the participant with the patient's copy of the form and point the patient to the Academy's website and toll-free number found on the materials to find a list of area dermatologists for follow-up treatment. If you provide a list, it may include your name, but, you should not make your name stand out in any way within a list of dermatologists in the area (e.g., your name could be listed in alphabetical order with the other names provided).
- All applicable state laws must be followed regarding your participation in the screening.
- I understand and agree that the Academy's SPOT Skin Cancer™ screening materials are the property of AAD and may not be shared with others outside my practice or used for any other purposes, including conducting skin cancer screenings that are not sanctioned by AAD.
- I further agree to comply with all HIPAA patient privacy rules associated with the skin cancer screening.
- I agree to the terms and conditions set forth herein, as well as any others that are included in the Academy's SPOT Skin Cancer™ Screening Program Guidelines, which I have reviewed and understood.
- I will not utilize my participation in this opportunity to publicize the health care products or services of any companies with which I have a relationship. **NOTE: This does not preclude screening physicians from displaying their certificates of participation or otherwise publicizing their involvement in AAD screenings.**
- I agree that I am not currently the subject of any governmental investigation or prosecution and that no adverse actions have been taken against any medical license that I hold, and that I have never been convicted of a felony. I further agree to notify the Academy if the foregoing representation changes in any way.
- I am not aware of any other relationships that I have or anything else in my background that could potentially create embarrassment for the Academy if I were to participate in the opportunity described above.
- If I provide any false information in this form or otherwise breach this agreement, I understand that I may be suspended from participating in any volunteer opportunities offered by AAD or its affiliates and must seek permission from the AAD Board of Directors to remove such suspension.

Print Name: \_\_\_\_\_ Circle one: MD, DO, PA-C, NP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Additional signature lines on the reverse side*

SPOT Skin Cancer™ Screening Opportunities

Attestation Form

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