STEPS TO BECOMING A *2010* CAMP VOLUNTEER

Friday July 16th – Sunday, July 18th
Preston County 4-H Camp
339 4-H Camp Road
Bruceton Mills, WV 26525

1. **Volunteer Application**—Please complete the following:

   - Application (including consents)
   - Authorization and Release for the Procurement of a Consumer and/or Investigative Consumer Report

Return applications:

Chris Garbart, Project Coordinator
Hospice Care
PO Box 760
Arthurdale, WV 26520

2. **Criminal Check**—Because of the intimate nature of our work in the community, Hospice Care conducts a criminal history check for all volunteers and paid staff. Please complete the last page (Authorization and Release for the Procurement of a Consumer and/or Investigative Consumer Report) and return this form with your application. ***Do not send in a check with this form; Hospice Care pays all fees.*** The purpose of this form is to allow us to conduct a criminal history check. Hospice Care does **not** check consumer information.

3. **Interview**—A Hospice Care staff member will contact you to set up a meeting time. *(Returning camp volunteers and/or current staff may not be subject to an interview.)*

4. **References** — Two (2) references are checked before training. (*Current Hospice Care staff and volunteers* references are not required.)

5. **Training**— Volunteer training, provided by experienced grief professionals, is mandatory for all camp volunteers and will be offered in two locations. Training in the grief process and communication skills prepares you to offer support to those who attend Camp Nabe. You will also receive important information regarding camp and the camp experience. Please use the attached training session form to let us know which you plan to attend if your application is accepted. ***Returning camp volunteers and/or current HCC staff and volunteers MUST ATTEND TRAINING***

6. **Transportation** – We encourage all volunteers to drive themselves to camp or get together with other volunteers to carpool.

Hospice Care prides itself in providing the very highest quality of care to each camper. Because of this commitment, all staff are screened and continually evaluated. Standards of conduct apply to both paid and volunteer staff ***YOUR COMPLETION OF THIS FORM DOES NOT GUARANTEE YOUR ACCEPTANCE INTO THE CAMP NABE PROGRAM***

For additional information, contact Chris Garbart, Project Coordinator at (304) 864-0884 or 1-800-350-1161

Please keep in mind that volunteers must be available from 4 PM on Friday, July 16th until early afternoon on Sunday, July 18th.

Volunteer Application
Camp Nabe sponsored by Hospice Care
Friday, July 16, 2010 – Sunday, July 18, 2010
Preston County 4-H Camp, Bruceton Mills, WV

Name: ____

Address: ____

City: _________________________________**State:** ____________**ZIP:**________________

Telephone number: Day: ___________________ **Evening:**_______________________

Email:____

DOB :______________________ **Age:**_______ **Gender: M**____ **F**____

Hospice Care Staff – please complete:

Position with HCC	Office Location	Office phone number

T-shirt size: ☐ **S** ☐ **M** ☐ **L** ☐ **XL** ☐ **XXL** ☐ **XXXL**

Have you volunteered for a weekend camp in the past with Hospice Care?
☐ **Yes.** What year? ____________________ ☐ **No**

How did you hear about Camp Nabe?

___ Returning camp volunteer
___ Special activity support
___ Work
___ Faith Community
___ HCC volunteer
___Flyer
___HCC Staff Member
___Media
___Friend
___Other, please specify

PART I. VOLUNTEER OPPORTUNITIES

What are your personal goals for Camp experience?

____

____

Volunteer Opportunities:

Please choose all area(s) of interest marking your preferred choices (1st, 2nd, 3rd etc). We will make every effort to accommodate your preferences, if possible

___ Adult Buddy
___ Junior Volunteer (18 yrs. old or younger)
___ Adult Camp Support
___ Clergy
___ Camp Readiness (prior to camp)
___ Support Staff (assisting with camp logistics)
___ Cabin Counselor
___ Presenter
___ Recreation activities leaders
___ Recreation activities (general help)

If applying to be an Adult Buddy, please number your age group choice (1st, 2nd. 3rd). All efforts will be made to accommodate your request, but we reserve the right to place you where needed.

Elementary ______ Middle School______ High School______

Would you like to speak to a veteran camp volunteer? ☐ **Yes** ☐ **No**

PART II. VOLUNTEER EXPERIENCE/TALENTS

Volunteer Experience (include description of responsibilities): ________________________________

____

____

Prior experience with children/teens: ____

____

Describe any talents, hobbies, or special interests you have: ___________________________

____

PART III. BEREAVEMENT HISTORY

This information is important to help match grief histories of volunteers and campers

Please indicate who died (i.e. your mother, brother, friend, etc.) *and* year of death	Your age at the time of the death	Cause of death and age of person who died

Use this space to further explain any responses or include additional information you feel will be useful in processing your application and matching your assignment for the weekend.

____

____

PART IV. REFERENCES

Please list below two references. Your references should include at least one personal and one professional reference.

Reference Name	Address	Phone Number	Relationship

PART V. HEALTH HISTORY

Please check all conditions that apply and explain any checked items below:

☐ Allergies
☐ Emotional Issues
☐ Seizures
☐ Asthma
☐ Hearing Impairment
☐ Special dietary needs
☐ Cancer
☐ Heart Problems
☐ Vision impairment
☐ Diabetes
☐ Physical Limitations
☐ Other

Please explain anything checked above:

____

Are you restricted from participating in any physical activity? ☐ Yes ☐ No

If yes, explain: ____.

NAME:____

PART VI. CURRENT EMERGENCY CONTACT INFORMATION

Person to notify in case of an emergency: ____

Relationship: ____

Address: ____

Day Phone ________________ Evening Phone ______________ Cell Phone _____________________

PART VII. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my participation in a Camp Nabe activity and I am unable to speak for myself, I consent to

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp Nabe Director/Nurse.

2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

Signature: ____ Date: ________________________

Name and phone number of physician: ____

Health Insurance Information

Name of Preferred Medical Doctor/Facility:____

Address: ____

Phone Number: ____

Health Insurance Provider: ____

Name of Policy Holder: ____

Identification Number: __________________ Group: ______________________________________

PART VIII. Releases

A. Statement of Confidentiality

I understand that information regarding Camp Nabe, its volunteers, campers, their families, and/or significant others and any other persons receiving support or services in any capacity is privileged information for use by and with authorized persons only. I will disclose such information only in the discharge of my duties and responsibilities with Camp Nabe, or persons authorized to receive such information through the signed consent of the camper's parent or guardian.

I will not disclose any information with any unauthorized person. I will handle any and all paperwork and forms with proper procedure of control so that no information is accidentally observed or released to any unauthorized persons. I also understand that the casual sharing of camper information in public places or settings is inappropriate.

I further understand and agree that any violation of this policy will justify my immediate discharge.

Signature: ____Date: ___________________

B. Liability Release

I understand and agree that Hospice Care Camp Nabe, its board of directors, officers, employees, and volunteers are released from any legal responsibility and/or liability for negligence arising out of any accidents or illnesses, which occur while I am attending Camp Nabe.

Signature: ____ Date: ___________________________

C. Media Consent and Release

Videotaping, photography, or both may occur during camp activities. I understand that such material may be used in both future publicity and educational efforts by Camp Nabe. In addition, with staff permission and supervision, news media may photograph, videotape, and/or interview some of the volunteers attending camp. I consent to having my voice and/or image recorded or photographed for use as outlined above.

Signature: ____ Date: __________________________

D. Criminal Background Check

For the purposes of my serving as a volunteer, I authorize Camp Nabe, Hospice Care, or other authorized representatives of the company bearing this release to obtain any information pertaining to my background, including any of these items: 1) current address 2) previous address 3) criminal search 4) traffic court search 5) motor vehicle report 6) sex offender registry 7) wants/warrants 8) social security number trace 9) verification of education; license; employment.

Signature: ____

Social Security Number____

Date: ____

E. Substance Abuse Agreement Consent

Volunteers may not engage in the unlawful possession, manufacture, distribution, solicitation, or use of controlled substances or alcohol on camp property or while volunteering during camp

Signature: ____ Date: __________________________

PLEASE NOTE: Your completion of this form does not guarantee your acceptance into the Camp Nabe program.

Please return to:

Chris Garbart, Project Coordinator
Hospice Care
PO Box 760
Arthurdale, WV 26520

304-864-0884, ext. 135 (phone)
304-864-3373 (fax)

Camp 2010 Volunteer Training

Please review this information below concerning the camp volunteer training sessions and check the one you plan to attend if you are chosen.

☐ **Monday, April 26, 2010**
6:00 p.m. – 9:00 p.m.
Hospice Care Office
3363 University Avenue
Morgantown, WV 26505

☐ **Thursday, May 6, 2010**
6:00 p.m. – 9 :00 p.m.
Hospice Care Office
3363 University Avenue
Morgantown, WV 26505

Name: ____

PLEASE RETURN WITH VOLUNTEER APPLICATION

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT
(PLEASE PRINT OR TYPE)

I, the undersigned consumer, do hereby authorize **Hospice Care Corporation,** by and through its independent contractor, **Horizon Medical Technologies,** to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character, general reputation, personal characteristics and mode of living, discerned through employment and education verifications; personal references; personal interviews; my personal credit history based on reports from any credit bureau; by driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request Horizon Medical Technologies if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et. Seq. I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to Hospice Care Corporation, by and through Horizon Medical Technologies, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity, or governmental agency compiled the information itself or received it from other sources.

I hereby release Hospice Care Corporation and any and all person, business entities, and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application or employment will be terminated based on any false, omitted or fraudulent information.

Signature: ____

Printed Name: ____Date: _____________
First Middle Last

____
Other names used (maiden, nicknames, alias, etc.)

Current Address: ____
Street/P.O. Box City State Zip Code County Dates

Former Address: ____
Street/P.O. Box City State Zip Code County Dates

Social Security Number:_____________________________ Date of Birth: ___________________

Telephone Number:_________________________________