



Date: Saturday, August 29, 2020

Location: Camp Mountaineer – 187 Camp Mountaineer Rd. Morgantown, WV 26508

Volunteer Application—Please complete the following:

- Application (including consents)
 - Authorization and Release for the Procurement of a Consumer and/or Investigative Consumer Report
- 1. Introduction**—Director of Camp Caring will contact you to speak further regarding application, fingerprint process, and answer additional questions, etc.
(You must be approved by Camp Caring Director to volunteer at Camp Caring)
 - 2. Criminal Check**—Because of the intimate nature of our work in the community, WV Caring 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; WV Caring pays all fees.*** The purpose of this form is to allow us to conduct a criminal history check. West Virginia does **not** check consumer information.
 - 3. Training**— Volunteer training, provided by experienced grief professionals, is mandatory for all camp volunteers. Training in the grief process and communication skills prepares you to offer support to those who attend Camp Caring. You will also receive important information regarding camp and the camp experience. Training dates will be set based on best availability for the most volunteers. Accommodations can be made as determined by Camp Caring Director for those who are unable to attend training dates.
 - 4. Transportation** – We encourage all volunteers to drive themselves to camp or get together

**For additional information, contact Kadie Baker-Camp Director at
304-290-9992 (cell) 304-599-4200 ext. 118 (office) or campcaring@wvcaring.org**

SUBMIT APPLICATION BY MAIL, EMAIL, OR FAX:

Camp Caring
3436 University Avenue
Morgantown, WV 26505

campcaring@wvcaring.org

Fax #- 304-599-1125

Camp Caring Volunteer Application 2020

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Secondary Number: _____

Email: _____

DOB: _____ Age: _____ Gender: M____ F____

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

West Virginia Caring Staff:

Position: _____

Have you volunteered for West Virginia Caring (formerly Hospice Care Corp) in the past?

☐ Yes. What year? _____ ☐ No

Volunteer Opportunities:

Please choose your area(s) of interest marking your preferred choice (1st, 2nd, 3rd)

Adult Budd _____

(Paired with a camper to help guide them through the whole day of camp)

Support Staff: _____

(Assisting with camp logistics)

PART II. VOLUNTEER EXPERIENCE

In the space below please provide prior volunteer experience and any past experiences with children:

PART III. BEREAVEMENT HISTORY

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

(Please indicate who died, your age at time of death, and cause of death)

Use this space include additional information you feel will be useful in processing your application and matching your assignment for the weekend.

PART V. HEALTH HISTORY

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

- | | | | | |
|------------------------------------|---|--|--|--------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Seizures | <input type="checkbox"/> | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing | <input type="checkbox"/> Impairment | <input type="checkbox"/> Special dietary | <input type="checkbox"/> needs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Vision impairment | <input type="checkbox"/> | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical | <input type="checkbox"/> Limitations | <input type="checkbox"/> Other | <input type="checkbox"/> |

Please explain anything checked above:

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

If yes, explain: _____.

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 Caring 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 Caring 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 Caring, 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 Caring, 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 West Virginia Camp Caring, 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 Caring.

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 Caring. 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 Caring, West Virginia Caring 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: _____

INVESTIGATIVE CONSUMER REPORT
(PLEASE PRINT OR TYPE)

I, the undersigned consumer, do hereby authorize **West Virginia Caring**, 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 West Virginia Caring, 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 West Virginia Caring 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: _____