

Camp Caring Volunteer Application 2026

Volunteer Information

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____ Texts? **Y N**

Email: _____

DOB: _____ Age: _____ Sex: **M F**

Tee shirt size: (adult) **S M L XL XXL XXXL**

Are you a member of WV Caring staff? **Y N** if yes, list position _____

Have you volunteered for WV Caring Hospice previously? **Y N** if yes, list year _____

Volunteer Opportunities

At Camp Caring, we need adult volunteers in two categories: Buddies and Support Staff. Please indicate which role you'd like to be considered for.

___ **Buddy**. This role spends the day of Camp Caring with a school aged camper, helping to guide them through the whole day and experience of camp. Buddies will be contacted prior to camp and given "get to know you" information about the campers to help prepare for the day. We match each camper with a buddy who might be especially resonant for their experience of grief, loss and life.

___ **Support staff.** This role helps everything before, during and after camp run smoothly. This might include set up, supply management, food delivery, and anything else that might be necessary on the day of Camp Caring. For support staff, you can sign up for a shift or the whole day.

Volunteer Experience

Let us know what your prior volunteer experience has included, or other relevant experiences or work.

In order to help us match buddies and campers, we'd like to know your own bereavement (grief) history or about the experiences that led you to volunteer as a buddy. Please indicate your relationship to the loss, how old you were at the time of your grief, and the cause of death.

If there is anything else you would like the Camp Caring team to know about you, please share that here

Health History

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

- | | | |
|-----------|----------------------|-----------------------|
| Allergies | Behavioral | Health Seizures |
| Asthma | Hearing Impairment | Special dietary needs |
| Cancer | Heart Problems | Vision impairment |
| Diabetes | Physical Limitations | Other |

Please explain anything checked above:

Current Emergency Contact

Name: _____ Relationship: _____

Address: _____

Phone: _____

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

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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: _____

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

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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: _____

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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: _____



WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

SELF-DISCLOSURE APPLICATION AND CONSENT FORM

PART I

I, the below-named applicant, understand that this form cannot be completed until an offer of employment is made. The offer of employment is made pending the results of the investigation of registries and a fingerprint-based background check. I understand that refusal to complete Parts I, II, and III of this form constitutes my rejection of the employment offer.

I, the below-named applicant, swear/affirm, that the information contained within this application is true and correct to the best of my knowledge.

Applicant Last Name: _____ First Name: _____ MI: _____ Generation (ex. Jr., II): _____

Clearly answer truthfully YES or NO to the following questions:

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you addicted to alcohol, a controlled substance or a drug or are you an unlawful user thereof? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been convicted of, pled guilty or nolo contendere (no contest) to a misdemeanor or felony in any state or federal court ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been convicted of an act of violence involving a deadly weapon or an act of domestic violence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you under indictment or do you have any criminal charges pending against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently serving a sentence of confinement, parole, probation or other court ordered supervision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you the subject of a restraining order as a result of a domestic violence act or subject to a verified petition of domestic violence or subject to a protective order? | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE: If any questions 1-6 listed above are answered YES, a brief letter of explanation by the applicant must accompany this form. Failure to provide explanations could result in disqualification.

PART II

Consent for Investigation for Employment Purposes and Acknowledgement of Receipt of Notice

I hereby authorize the Department of Health and Human Resources (DHHR) to conduct an investigation including, but not limited to, registry and state and federal fingerprint-based background checks, into information contained in this application. I understand that my fingerprints will be retained by the West Virginia State Police for the purpose of RapBack services during my employment in a WVCARES covered provider. **Furthermore, I understand that the falsification of any information contained within this application constitutes false swearing and is an excluding act under the fitness determination process being conducted by DHHR.**

I, _____, acknowledge receipt of the information contained in the Notice to All Applicants.
(Applicant's printed name)

Signature of Applicant: _____ Date: _____



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SELF DISCLOSURE APPLICATION AND CONSENT FORM

PART III

Applicant Last Name: _____ First Name: _____ MI: _____ Generation (ex. Jr., II): _____

Gov't Issued ID Number/Expiration: _____ State of Issue: _____ Type of ID: _____

Gender: Male Female Race: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Hair Color: Brown Blonde Bald Black Gray Other Red White
Eye Color: Blue Hazel Brown Red Black Other Green Gray

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Place of Birth (City & State): _____ Citizenship: _____

Current Mailing Address: _____ County: _____

Current Physical Address: _____ County: _____

List all cities and states (outside of WV) where you have lived within the past 5 years and provide approximate dates:

List all cities and states (outside of WV) where you have worked within the past 5 years and provide approximate dates:

List all names and aliases you have used formally and informally (Include maiden names, married names, nicknames, and any other name used or known as):

For Office Use Only (This form expires 60 days after the date of the signature in Part II):

I affirm that I have compared the government issued identification presented by the applicant.

Signature: _____ Date: _____

Printed Name: _____ Position: _____



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West Virginia Clearance for Access: Registry and Employment Screening

NOTICE TO ALL APPLICANTS

Obtaining Criminal History Report: An individual may request a copy of his or her own criminal history report (or proof that one does not exist) for a personal review by visiting MorphoTrust at www.identogo.com or calling 1-855-766-7746.

Appeals: If the applicant wishes to challenge the information contained in the identity history summary, a challenge of record may be filed pursuant to W.Va. St. R. §69-10-8 with the WV State Police at <http://www.wvsp.gov/Criminal%20Records/Pages/default.aspx> and/or the FBI at <https://www.fbi.gov/services/cjis/identity-history-summary-checks>.

PRIVACY ACT STATEMENT:

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

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West Virginia Clearance for Access: Registry and Employment Screening
AMAP ELIGIBILITY REQUEST AND CONSENT FORM

PART I

Consent for Investigation for Employment Purposes

I hereby authorize the Department of Health and Human Resources (DHHR) to conduct an investigation including, but not limited to, registry and fingerprint-based background checks, for the purpose of determining eligibility for employment as an Approved Medication Assistive Personnel (AMAP) pursuant to W. Va. Code St. R. §64-60-6.

Applicant Name (Please Print): _____

Signature of Applicant: _____ Date: _____
(Signature must be completed in blue ink)

PART II

Facility/Agency Name: _____

Applicant Name: _____

Applicant DOB: _____

Date of Fingerprints: _____

TCN: _____

Authorized Facility/Agency Representative: _____

Title: _____ Date: _____

AMAP Requests must be submitted to amapwvcares@wv.gov. Do not upload forms to the WV CARES, as they will not be processed.

For WV CARES Use Only:

Received: