Thank you for your interest in becoming a volunteer for Family Counseling Service of Northern Nevada!

Please fill out the following application COMPLETELY. If you have questions, please call us at:

(775) 329-0623, we are available and happy to assist you. Please email the finished application to [tiffany@familycounselingservice.org](mailto:tiffany@familycounselingservice.org) or bring it to our office located at 1475 Terminal Way STE D.

Please keep the following in mind when completing your application:

* Your typed name serves as your signature for these forms, should you chose to complete them electronically.
* Once your application is received and accepted, you will be sent a form for fingerprint background checks.
* You must attend the entire week of camp if volunteering.
* You must attend a mandatory volunteer meeting prior to camp. Please click the link below to choose a camp training date: [**https://www.signupgenius.com/go/10C0E48ADAF2EABF4C52-camp**](https://www.signupgenius.com/go/10C0E48ADAF2EABF4C52-camp)

You will need to have your fingerprints done no later than May 30th in order for us to receive the report in time for you to attend camp. Please finish and submit the application before requesting a fingerprint and CANS form. We understand that emergencies arise, and life happens. However, if you fail to show up for camp for which you are accepted, you may be charged for the cost of fingerprinting/ background checks.

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Name: Age: \_\_\_\_\_\_ DOB:

Mailing Address:

P. O. Box or Street City, State Zip Code

Physical Address (if different):

Street Address City, State Zip Code

Phone: Adult Shirt Size: \_\_\_\_\_ E-Mail:

*Please note, to be able to volunteer, you will need to be able to pass a background check. All applications must be turned in with enough time to fully process the background check. Please turn in your application by May 30th. If you complete the background check, but are unable to volunteer, you will be responsible for the cost of the background check.*

Education:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School | Years Attended | Name of School | City | Did you graduate? |
| High School |  |  |  | YES or NO |
| College |  |  |  | YES or NO |
| Other |  |  |  | YES or NO |

Military Service Record: YES \_\_\_\_\_\_ NO \_\_\_\_\_\_ If so, list branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and discharge date:\_\_\_\_\_\_\_\_\_

Work and Volunteer Experience:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Company | Dates | Title or Job Description | Duties | Company Phone | Reason for Leaving |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

References (3):

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Address | Occupation | Telephone |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Signature Date

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX G**

**WAIVER AND RELEASE OF LIABILITY**

**(Camper/staff/volunteer – Adult)**

**Release and waiver of liability and indemnity agreement.** I further agree to indemnify, protect, defend and hold harmless Camp Ronald McDonald at Eagle Lake, Ronald McDonald House Charities Northern California and their directors, officers, employees, volunteers, and/or agents from and against any cost, damage, expense, claim, or liability caused by or arising out of my use of, presence at, or trip to or from the facilities of Camp Ronald McDonald at Eagle Lake, including any injury to or death of any person, any damage to any real or personal property on or about the Camp or belonging to Camp Ronald McDonald or Ronald McDonald House Charities Northern California and any attorney’s fees and/or costs arising out of this Agreement.

I, the undersigned, hereby waive any and all claims that I or my heirs may have against the directors, officers, employees, volunteers, and/or agents of Camp Ronald McDonald at Eagle Lake or Ronald McDonald House Charities Northern California for any injuries or property damages which may arise while on the Camp Ronald McDonald premises. I acknowledge that this waiver includes any claim for wrongful death, personal injury or property damage caused by or rising out of the negligence of Camp Ronald McDonald at Eagle Lake, Ronald McDonald House Charities Northern California, or their directors, officers, employees, volunteers and/or agents.

**Authorization for use of photo**. I hereby authorize Camp Ronald McDonald at Eagle Lake and Ronald McDonald House Charities Northern California to use, for any purpose whatsoever, any photograph (including digital media and videotape) taken at or near Camp Ronald McDonald at Eagle Lake that contains my likeness.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Volunteer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Session: \_\_\_\_\_\_\_\_\_July 9th -15th 2023\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Volunteer Background Check**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Family Counseling Service of Northern Nevada, Inc. to have the Washoe County District Attorney’s Office or the Washoe County Sheriff’s Department complete a check of my background using my Social Security Number and Date of Birth for any criminal activity.

Print Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accompanying this form please provide a front and back copy of your state issued identification.**

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF NEVADA

CONFIDENTIALITY AGREEMENT

I acknowledge that during the course of performing my assigned duties as a Substance Abuse Prevention Treatment Agency (SAPTA) provider I may have access to, use of, or disclose information which is protected by federal and state law. I hereby agree to consider this information as confidential and handle such information in a confidential manner at all times during my time as a provider.

Definitions:

**Confidential Information**: any individually identifiable information, health information or other information in any form or media.

**Breach**: Any unauthorized acquisition, access, use, or disclosure of confidential, protected health information is presumed to be a breach, unless it can be demonstrated that there is a low probability that PHI has been compromised based upon a risk assessment.

1. I will use and disclose (request, obtain, or communicate) confidential information provided, viewed, or made available by SAPTA only in connection with and for the purpose of performing my assigned duties.
2. I will use and disclose (request, obtain, or communicate) confidential information provided, viewed, or made available only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more information than is necessary to accomplish assigned duties.
3. I will take reasonable care to properly secure all information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when tasks are completed, I will log off my computer or use a password protected screensaver in order to prevent access by unauthorized uses. All information I transmit by email, mail, fax, or other electronic means will be secured.
4. I will not disclose my personal password(s) to anyone. I will not record or post passwords in an accessible location.
5. I will use and disclose information solely in accordance with HIPPAA Privacy and Security Rules. I will also agree to comply with any HIPAA Training requirements.
6. I will immediately report any unauthorized use or disclosure of confidential information of which I become aware to my Program Analyst and the Division of Public and Behavioral Health’s HIPAA Privacy Officer, utilizing the attached form to report a breach within 24 hours upon discovery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Volunteer Signature Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covid Requirements Form**

* Volunteers are required to be fully vaccinated or present a negative covid test 72 hours before attending camp.
* Volunteers coming from Las Vegas are required to wear a mask for the duration of their flight to Reno.
* All participants will be tested prior to departure from FCS to camp on July 9th
* **PLEASE EMAIL A PICTURE OF CDC PROVIDED DOSE CARD TO** [**kate@familycounselingservice.org**](mailto:kate@familycounselingservice.org) **or** [**tiffany@familycounselingservice.org**](mailto:tiffany@familycounselingservice.org)
  + Date of first dose: \_\_\_\_\_\_\_\_\_
  + Date of second dose: \_\_\_\_\_\_\_\_\_
  + Booster (if applicable): \_\_\_\_\_\_\_\_\_
* Volunteers should not attend camp if they have experienced the following symptoms 72-hours prior to camp:
* fever or chills
* cough
* shortness of breath or difficulty breathing
* fatigue
* muscle or body aches
* headache
* new loss of taste or smell
* sore throat
* congestion or runny nose
* nausea or vomiting
* diarrhea
* Volunteers should not attend camp if they have been in close physical contact 14-days prior to camp:
  + Anyone who is known to have laboratory-confirmed COVID-19
  + Anyone who has any symptoms consistent with COVID-19
* Volunteers are required to follow all the COVID-19 safety rules provided by staff

Volunteer Printed Name:

Volunteer Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tell us more about you…

Have you attended camp before? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you have attended camp before;

How many years have you attended? \_\_\_\_\_

What did you feel went well?

What would you recommend for improvement?

How did you hear about camp?

Please tell us why you want to volunteer at FCS Summer of Healing Camp?

Please tell us what you hope to gain from your camp experience?

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone Number: ( ) \_\_\_

Address: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

**Dietary/Allergies**

Any dietary restrictions or allergies? (i.e. vegan and vegetarianism, peanut allergies, lactose intolerance, and gluten intolerance)

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Allergies: ex: seasonal, animal dander, bug bites/stings etc.

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_