# CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK IN COMPLIANCE WITH THE FCRA (FAIR CREDIT REPORTING ACT)

| Date | Driver Lic.# (if checking driving | Driver Lic. State |
|---|---|---|
| Last Name | First Name | Middle Name |
| Maiden and/or Other Last Names | | |

| Address* | City* | County* | State* Zip* |
|---|---|---|---|
| Date of Birth** | Social Security Number** | | Circle One**: ◯ Male / Female ◯ |

This authorization and consent for release of personal information acknowledges that **Easter Seals Serving DC, MD, & VA.** (Hereafter referred to as "Company"), may now, or at any time I am assigned to, volunteer with or am employed by this Company, conduct investigations whether the records are of a public, private or confidential nature. These investigations might include, but are not limited to, searches of educational institutions attended; state driving records; financial or credit institutions, including records of loans; records of commercial or retail credit agencies; other financial statements; records of previous employment, including work history, efficiency ratings, complaints and grievances filed by or against me; records and recollections of attorney-at-law or of other counsel, whether representing me or any other person (in either a civil or criminal case in which I have been involved); records from the U.S. Veterans' Administration; criminal history information of file in local, state or federal agencies; and motor vehicle records, and following an employment offer, workers' compensation reports from either the Department of Labor, National Personnel Records or the Industrial Commission or similar agencies under the provisions of the Fair Credit Reporting Act 15, USC section 1681 et seq. I also authorize the National Personnel Records Center, or other custodian of my military service record, to release to Easter Seals, the following information and/or copies of documents from my military service record: DD214, service record, and any disciplinary records.

I understand that these searches will be used to determine work assignment or employment eligibility under the company's employment or volunteer policies. Therefore, I authorize and consent for full release of records (either orally or in writing) to the authorized representatives of the company. In addition, I release and discharge the company and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that according to the Federal Fair Credit Reporting Act, I am entitled to know whether employment was denied based upon the information obtained and to receive, upon written request, a disclosure of the background report. After reading this document, I fully understand its contents and authorize the background verification.

Are you applying for employment in California, Minnesota or Oklahoma? Yes ☐ No ☐

If so, do you want a copy of any Consumer Report prepared concerning you? Yes ☐ No ☐

I understand that California law required Company to give me a copy of any report requested within seven (7) days of the date the information was obtained and that failure to do so will expose Company to liability (Section 1786.29).

*** AS SHOWN ON THE ORIGINAL APPLICATION**

**** TO BE USED ONLY FOR CRIMINAL HISTORY SEARCHES.**

**I HEREBY CERTIFY THAT ALL INFORMATION PROVIDED IN THIS AUTHORIZATION IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT IF ANY INFORMATION PROVES TO BE INCORRECT OR INCOMPLETE THAT GROUNDS FOR THE CANCELING OF ANY AND ALL OFFERS OF EMPLOYMENT WILL EXIST AND MAY BE USED AT THE DISCRETION OF Easter Seals Serving DC, MD, & VA.**

**Signed this _____ day of _____, 20_____**

**Applicant (Print Name) _____**

**Applicant Signature _____**



**Complete address information for the past 10 years on page 2**

| | | | | |
|---|---|---|---|---|
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | Zip* |
| Address* | City* | County* | State* | |
| Address* | City* | County* | State* | |

## Consent to Complete Background Checks on Volunteers

I am applying to volunteer with the Easter Seals Family Friends Respite Program. I understand that as a program requirement, all volunteers must consent to have background checks completed prior to approval for volunteer services. Anyone whose record indicates a felony or misdemeanor conviction in an area which causes concern for the safety and well-being of children and families will not be accepted as a volunteer. Personal references which indicate or allude to past or present illegal and/or unethical behavior(s) on the part of the potential volunteer may also prohibit acceptance of the individual into the volunteer program. In addition, any information received by Easter Seals from authorized sources eg. other agencies, employers, volunteer programs, regarding past or present unethical/illegal conduct on the part of a volunteer currently volunteer with Easter Seals will result in investigation and possible removal of that volunteer from the position.

I am consenting for Easter Seals to complete the following background checks.

- ☑ Reference Checks
- ☑ Criminal Background Check
- ☑ Child Abuse Background Check
- ☑ FBI Fingerprint Check
- ☑ Driving Record Check
- ☑ First Check – Social Security Check

I am providing my personal identification information to Easter Seals to provide background checks.

| First Name | Middle Name | Last Name | Alternate/Maiden Name |
|---|---|---|---|
| | | | |

| Social Security Number | Date of Birth | Driver ID and State Issued |
|---|---|---|
| | | |

| Address (Street) | City and County | State | Zip Code |
|---|---|---|---|
| | | | |

**My signature below indicates that I have read the policy as state above and understand the screening guidelines used to select volunteers.**

Signature Date

Easter Seals Staff Signature Date

## Medical Authorization

I, _____, give my permission for
(Participant)
_____, to obtain any necessary medical treatment for
(Easter Seals Representative)
me, if necessary. I agree to assume any legal and/or financial responsibilities that may arise through the use of this authorization. My insurance (or medicaid) policy numbers are:

---

---

This authorization is to be in effect whenever I 'am participating in an Easter Seals Respite Services Program event or activity.

_____ _____
Signature of Participant Date

_____ _____
Signature of Easter Seals Staff Date

# ADULT MODEL PUBLICITY RELEASE

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easter Seals Serving DC | MD | VA or its respective employees and agents may be used by Easter Seals Serving DC | MD | VA, and those acting with its permission, for the purpose of illustration, websites, Facebook, twitter, broadcast, or testimonial in connection with any work of Easter Seals Serving DC | MD | VA and that these materials may be released to the general public. I assign to Easter Seals Serving DC | MD | VA all of my rights to these materials.

I understand that these materials made by Easter Seals Serving DC | MD | VA, its employees and agents are owned by Easter Seals Serving DC | MD | VA and that they may copyright them. I understand that these materials may be published on Easter Seals Serving DC | MD | VA' network of Web sites.

Easter Seals Serving DC | MD | VA does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easter Seals Serving DC | MD | VA may decide not to use them.

I acknowledge that the rights described above are granted to Easter Seals Serving DC | MD | VA on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easter Seals Serving DC | MD | VA will not condition any treatment or funding to me on the completion of this authorization.

I certify that I am over the age of 18 years old.

I have read this release and authorization before signing below, and I fully understand its contents.

_____ _____

Name Witness for Easter Seals Serving DC | MD | VA

_____ _____

Date Date

_____

Address

_____

City, State, Zip Code

## CONFIDENTIAL INFORMATION STATEMENT

I understand that the information considered confidential involves all reports within the medical records, employee health records, and/ or automated information systems concerning examinations, tests, treatments, observations, and diagnosis of the clients/employees of Easter Seals Serving DC | MD | VA. It also includes information I learn in conversations with other employees or in reference to donors' information. I understand that demographic information, including all specific financial data, is private.

I understand and agree that as a Volunteer/Intern/Trainee of Easter Seals Serving DC | MD | VA, I must hold certain confidential information in strict confidence, regardless of method of communication, including but not limited to hard copy, faxed, electronically transmitted, oral conversations, or any printed data. This confidence must be kept when performing my duties, as well as during breaks, rest periods and time away from work. I understand that I may not seek access to or release written or computerized confidential information unless my work assignment specifically authorizes me to do so.

I understand that discussions concerning confidential information are not to occur in hallways, elevators, or other public areas where someone not authorized to receive the information can inadvertently overhear confidential information. I understand that when I discuss confidential information, I must take precautions so that unauthorized persons will not overhear my discussion.

I understand that the combination of logon and password codes forms my electronic signature. Divulging my password code or that of another or utilizing the password code of another or allowing someone else to use mine is not permitted. If I leave the work area, I will sign off the application/system to prevent unauthorized access.

I will abide by HIPAA privacy regulations for protected health information that include: individually identifiably information that is transmitted or maintained by Easter Seals Serving DC | MD | VA as it relates to individuals past, present or future physical/mental health or describes individual's past, present or future payment for healthcare.

I am aware of my Volunteer/Intern/Trainee status as a ☐ direct classification ☐ indirect classification as it relates to client protected health information access.

***Consequences for Violation***

I understand that any breach of confidentiality and terms of this statement will be considered a violation of company policy and may result in disciplinary action up to and including dismissal from my volunteer/intern/trainee position.

NAME (PRINTED) _____

SIGNATURE _____ DATE _____

SUPERVISOR/ DIRECTOR SIGNATURE _____ DATE _____

## EMERGENCY CONTACT INFORMATION

Volunteer Name: _____

Volunteer Birthdate: _____

**Family/Emergency Contact Person**:
*Please provide us with the best person to contact in the event of an emergency.*

First Name: _____ Last Name: _____

Relationship to Volunteer: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Contact Number: Home _____ Cell _____ Work _____ Alternate _____

**Primary Physician:**

First Name: _____ Last Name: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Contact Number: _____

**Do you have any allergies to medications, foods, etc?**
☐ No ☐ Yes
If yes, please describe:
_____
_____

## Volunteer Screening Form

Date of Contact: _____

First Name: _____ Last Name: _____ Age: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Contact Number: Home _____ Cell _____ Work _____ Alternate _____

Email Address: _____

*Each volunteer will be matched with a child for the day and will work with a team of volunteers. All volunteers must attend a pre-respite training session at 8:30AM the day of the event and provide their own transportation to Easter Seals Inter-Generational Center in Silver Spring, MD. Please note you will stay with your child until the parents have arrived for pick-up.*

1.) How did you hear about this opportunity?

2.) Do you have any experience working with children? Please explain in detail.

3.) Do you have any experience working or spending time with people with disabilities? Please explain in detail.

4.) Is there any type of disability you would not be comfortable with (i.e. non-verbal, wheel chair)?

5.) Would you be comfortable working with an active child (i.e. quick on his/her feet, high energy level)?

6.) Do you have experience working with babies and/or young toddlers?

7.) Do you have any preferences that would help us select the best child for you (age, gender, disability)?

8.) Trips may require extensive periods of standing & walking. Are you comfortable with that?

9.) For community trips, will you be available to ride on the bus to and from the event location?

10.) Would you be interested in additional training (training on autism, etc)?

11.) Do you know of any friends, family, co-workers, etc who may be interested in the Program?

12.) Any additional comments, questions, or concerns you may have?

Please provide us with the name, phone number and/or email address of at least 2 references.

Name: _____ Name: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

## Waiver of Liability

I agree that the Easter Seals Serving DC | MD | VA RESPITE SERVICES PROGRAM, its employees, all volunteers and other participants in the Easter Seals Respite Services Program will not be held responsible or liable for consequences resulting from any incident which might be construed to adversely affect my health, safety or welfare. I also understand that neither Easter Seals nor its employees, other participants, sponsoring agencies, individual sponsors, advertisers, and if applicable, owners and leasers on premises used to conduct the program will assume responsibility for any injury, disability, death, or loss or damage to person or property, accidents, medical, dental, or other expenses incurred as the result of accidents sustained during participation in the program whether arising from negligence or otherwise.

I knowingly waive all my rights to hold Easter Seals Serving DC | MD | VA, its employees and other participants liable as a result of any incident which might be construed to adversely affect my health, safety, or welfare.

I make this agreement in consideration of my participation in the RESPITE SERVICES PROGRAM.

I have fully disclosed to the RESPITE SERVICES PROGRAM, information about my physical and mental health which might affect performance as a program participant, and I acknowledge full responsibility for any consequences of my failure to disclose that information.

I agree to follow all procedures, policies, and practices established by the Easter Seals Serving DC | MD | VA RESPITE SERVICES PROGRAM while participating in the RESPITE SERVICES PROGRAM.

I have read this agreement and voluntarily and knowingly agree to the terms contained herein.

_____ _____

Signature of RESPITE SERVICES participant Date

_____ _____

Signature of Easter Seals Staff Date

## Volunteer Checklist

Please check the appropriate boxes below for forms that are fully completed.

- ☐ Consent to complete Background Checks (Please return this as soon as possible—does not need to accompany additional forms)
- ☐ Medical Authorization
- ☐ Publicity Release
- ☐ Confidential Information Statement
- ☐ Emergency Contact Information
- ☐ Volunteer Screening Form
- ☐ Waiver of Liability