ROSEMOUNT CENTER
Application for Volunteering

Thank you for your interest in contributing to Team Rosemount!

For Rosemount Office Use Only

Received		Document
	1.	Application
	2.	Waivers to sign
	3.	Criminal Background Check
	4.	Health Information Forms

Application

Applicant's Name:	
Date:	
Address:	
Telephone Number:	Home_____Office_____Cell_____
Date of Birth: **(must be at least 16 years of age to volunteer unless part of a documented school program) (Volunteers over 18 years need only fill in month and day)**	
Email Address:	
Position desired:	
Emergency Contact	Name:
	Relation:
	Address:
	Telephone number(s):
Car	Make, Model, Tag#

Confidentiality of Rosemount Client Information

I have read this statement and understand that all Rosemount Center information regarding families, children, staff, and consultants is considered confidential. I will have access to and will be dealing on a professional basis with information related to confidential matters which include but are not limited to the following information: Child/family health and financial status; employee health information and medical status when applicable, child file folders; cognitive and developmental profiles for children; screening and assessment results; employee yearly evaluations; disciplinary actions; employee salary status; and other personal information related to the children and families that the Rosemount Center serves.

I agree not to disclose confidential information. I agree not to disclose or discuss any confidential information unless it is necessary for the validation of credentials prior to employment or for a check of references necessary to follow employment guidelines and procedures.

I understand and agree that my disclosure of confidential information to staff, family members, children's families, former employees and third parties outside the scope of employment with the Rosemount Center will result in reprimand and corrective action which may include termination of employment, internship, volunteer opportunity with the Rosemount Center.

In addition, I understand that the presentation of falsified documents for degree certification, altering of personnel files, misrepresentation of my employment history, or misappropriation of Rosemount Center funds will be grounds for immediate termination.

Declaration

As required by Head Start Standard 1301.31, you must declare and list the following in the space below:

1. All pending and prior criminal arrests and charges you have related to child sexual abuse and their disposition. If there are none, please write NONE: _____

2. All convictions you have related to other forms of child abuse and neglect. If there are none, please write NONE: _____

3. All convictions you have of violent felonies. If there are none, please write NONE: _____

EL CENTRO
ROSEMOUNT
CENTER
A Great Place to Start

Technology Code of Conduct Agreement

I agree to abide by the rules and policies enumerated concerning use and confidentiality of the Rosemount Center's Information Technology Systems, including:

1) I agree to exercise maximum care and consideration of the equipment with which I have been entrusted.

2) I understand that this equipment is provided for my use in conducting Rosemount Center official business.

3) I agree not to download any programs from the Internet without clearance from systems administrators.

4) I agree not to open e-mail messages of unknown origin.

5) I understand that accessing or downloading of pornographic materials is grounds for dismissal from the Rosemount Center.

6) I understand that employees should maintain no expectation of privacy with regard to the use of the Rosemount Center computer network. System administrators can and will monitor all information stored within the system.

7) I understand the confidentiality of information available to Rosemount employees and the need to safeguard such information.

8) I understand all of the training that has been provided to me on network operations.

Print Name	**Your Signature**	**Date**

ASSUMPTION OF RISK, WAIVER OF LIABILITY AND INDEMNIFICATION AGREEMENT

I have read and understand all materials provided for the Volunteer Classroom Aide, Tutor, or Event Assistant Program for which I am applying, including the Handbook and Policies and the conditions of participation. I understand the nature of the Program for which I am applying and accept any and all risk involved in my participation.

I agree to release Rosemount Center and their agents and assigns for any and all liability and responsibility of any nature for any loss or damage to property or personal injury I incur while participating in the Volunteer Classroom Aide, Tutor, or Event Assistant Program or any other activity related to that Program. Any individual upon bringing legal action against Rosemount Center that result in a decision in favor of Rosemount Center will be responsible for all legal fees, court costs, and out of pocket expenses of Rosemount Center, its agents, and its assigns.

I also agree to indemnify and hold harmless Rosemount Center and its agents and assigns for any and all claims and liability arising out of or in any way relating to my conduct as a Volunteer Classroom Aide, Tutor, or Event Assistant at Rosemount Center. I understand that I will be held responsible for any injury or damages resulting from my conduct, including personal injuries and damages real or personal property. Jurisdiction for all legal action will be in the District of Columbia.

I will notify Rosemount Center in writing if I have medical conditions about which emergency medical personnel should be aware. In case of emergency during my service as a Volunteer Classroom Aide, Tutor, or Event Assistant, please contact:

Name _____

Telephone _____

I have carefully read this release and fully understand its terms.

_____
Signature of Participant

_____
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION

CHILD DEVELOPMENT FACILITY VOLUNTEER/EMPLOYEE HEALTH INFORMATION
(Print or type)

Facility: **ROSEMOUNT CENTER**

Address: 2000 Rosemount Avenue, NW Washington DC/20010
Street City State/Zip Code

Telephone: (202) 265-9885

Employee Name: _____

Date of Birth: _____

Employee Address: _____
Street City State/Zip Code

Telephone: Home_____Office_____Cell_____

Known Allergies: _____

Physician: _____ Telephone: ( ) _____

Address: _____
Street City State/Zip Code

Person to be contacted in an emergency:

Name: _____ Relationship: _____

Address: _____
Street City State/Zip Code

Telephone: ( ) _____

I have ☐ have no ☐ health insurance (check one).

Health Insurance Company: _____

Insurance Coverage: _____

Volunteer Signature: _____ Date: _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION

CHILD & RESIDENTIAL CARE
FACILITIES DIVISION
Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:
825 North Capitol Street, NE
Second Floor, Suite 2224
Washington, DC 20002

VOLUNTEER/STAFF HEALTH CERTIFICATE

Name: _____ Sex: [ ] Male [ ] Female

Name of Facility: **ROSEMOUNT CENTER**

Date of Birth: _____ Telephone No _____

Home
Address: _____

I have examined the above named person and certify that he/she is:

[ ] Free from disease in communicable form.

[ ] Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to children.

[ ] Can lift up to 25 lbs, when working with children

In addition to a general physical health examination, the following tests have been done:

Tuberculin test: [ ] Tine [ ] PPD

Date: _____ Result: _____

Chest X-Ray [ ] Date: _____ Result: _____

Remarks: _____

_____

_____

_____ MD/NP _____
Signature of Examining Physician/Nurse Practitioner Date of Examination

_____ Telephone No: _____
Address (Area Code)

EL CENTRO
ROSEMOUNT
CENTER
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Dear Doctor:

The purpose of this letter is to inform you of the Health Services requirements of our program.

All volunteers and employees in our program are required to obtain:

- **TB test and/or chest X-Ray performed within the last 12 months**

We also request:

- **Name of the physician**
- **A signature of the physician**
- **Address of the physician**
- **Date of examination**
- **Please complete all mandatory items requested**
- **Please certify that employee can lift up to 25 lbs, when working with children.**

Thank you for your cooperation. Should you have any questions, feel free to contact me at (202) 265-9885 ext 123 during the day.

Sincerely,

Gustavo O. Martinez
Health Services Manager

Background Check Instructions

You will be required to complete three types of criminal background checks in order to volunteer at Rosemount: the Child Protection Register Check, the Federal Background Check, and the DC Background Check. Instructions for each are provided below.

Instructions for the Child Protection Register Check

1. Complete Parts II and III of the form in this packet but do not sign your name.
2. You must take the form to a Notary Public who will complete Part IV of the form and ask you to sign in their presence. *(Please note: Rosemount has a Notary Public on site who can assist you with this process for nominal charge of $3.)*
2. Return the form to Rosemount Center, who will submit it on your behalf.

Instructions for the Federal Background Check

1. You must be fingerprinted by an accepted service to begin the Federal Background Check process. Follow the instructions on the attached "Child Development Home Provider/Employee Background Check Scheduling Guide."
2. Visit Fieldprintdc.com to schedule a fingerprinting appointment at the site of your choice. Enter Rosemount's Fieldprint code: FPOSSEDEL.
3. Bring the receipt provided to you at your fingerprinting appointment to Rosemount.

Instructions for the DC Background Check

1. You will need to complete a PD Form 70 (Criminal History Request) for a record check. This form is only available by visiting the Arrest and Criminal History Section of DC Police Headquarters, Monday-Friday between the hours of 9:00am and 5:00pm at the following address. (*The closest metro station is Judiciary Square. When you enter the building, take the elevator down to the first floor and follow the signs for Room 1075.*)

   MPDC Headquarters
   300 Indiana Avenue, Room 1075
   Washington, DC 20001
   (202) 727- 4245
2. You must bring one of the following to DC Police Headquarters:
   - Original Government Issued Photo ID

     -OR-
   - Original Birth Certificate AND Social Security Card
3. The cost of the background check is $7, and they do not accept credit cards or personal checks.

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

Child Development Home Provider/Employee Criminal Background Check Scheduling Guide

To schedule a fingerprinting appointment, please follow the instructions below:

1. Visit **Fieldprintdc.com**
2. Enter an email address under "New Users/Sign Up" and click the "Sign Up" button. Follow the instructions for creating a Password and Security Question and then click "Sign Up and Continue".
3. Enter the Fieldprint Code: **FPOSSEDEL**
4. Enter the contact and demographic information required by the FBI.
    - **Employer:** Your name or the name of the Home Provider you are employed by, address and telephone number
    - **Billing Code:** Superintendent of Education
    - **Position:** Childcare Provider
    - **Agency:** OSSE
    - **Organizational Unit:** Leave this field blank
5. Schedule a fingerprint appointment at a location of your choosing.
6. Print the confirmation page.
7. Take the confirmation page with you to your fingerprint appointment, along with two forms of identification (one must be a government-issued identification card).
8. If you have any questions or problems with the site, please contact Fieldprint's customer service team at 877-614-4364 or **customerservice@fieldprint.com**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Request for a Child Protection Register (CPR) Check

The purpose of the Child Protection Register is to protect children and to ensure their safety by maintaining an index of perpetrators of child abuse and neglect in the District of Columbia. This confidential index includes the names of individuals with substantiated and/or inconclusive findings from the investigative reports of the Child Protective Services Unit of the Child and Family Services Agency. Authorized individuals may request background checks to establish whether an individual has a record of substantiated abuse or neglect of a child that occurred in the District of Columbia.

- To request a local police clearance for the District of Columbia, please visit https://mpdc.dc.gov/node/187552.
- For information about the Sex Offender Registry, visit: https://mpdc.dc.gov/service/sex-offender-registry.
- If you are making a request on behalf of a state child welfare agency outside of the District of Columbia and need the history of a family previously living in the District of Columbia, you may call 202-671-SAFE.
- For other questions, call the CPR Unit at 202-727-8885 between 8:30 am and 4:30 pm Monday through Friday.

Read all instructions – incomplete, incorrect or illegible forms will be returned and your request may be delayed

- Do not complete a photocopy of this form – obtain the latest form online at https://cfsa.dc.gov/.
- Mail or deliver original application (no photocopies); no faxed, emailed, or scanned applications accepted.

Part I

- Schools (other than DCPS), child care facilities, private foster care agencies, and other private, community-based organizations should select "Non-Government Organization" as the Requestor Type.
- CPR check results are not transferrable and cannot be shared from one agency or employer to another.

Part II

- If you have no middle name write "no middle name" or if a middle name is an initial, indicate "initial only."
- If the answer to any question is none, write "N/A".

Part III

- An individual must sign the form to provide consent for CFSA to release information to an authorized requestor.
- The form must be signed in blue ink; electronic signatures are not permitted.
- An employment request allows access to substantiated reports of child maltreatment, to chief executive officers or directors of day care centers, schools, or any public or private organization working directly with children, for the purpose of making employment decisions.

Part IV

- Forms shall be returned if not notarized (*Note: applications for prospective and current CFSA resource parents and kin caregivers need not be notarized, but photo ID must be provided and the form must be signed in the presence of a CFSA employee*).

Part V

- Self-check applications must be submitted in person, not by mail.
- Individuals requesting a self-check and CFSA resource parents and kin caregivers must present **one** non-expired, government-issued, photo identification: e.g., driver's license, state identification card, passport, "green card".
- Results of CPR self-checks may not be used for employment purposes. Employers must directly request CPR clearances for prospective or current employees.

MAIL or HAND DELIVER completed forms to:	Attn: Child Protection Register Unit Child and Family Services Agency 200 I Street SE, 3rd Floor Washington, DC 20003	**Applications accepted between 8:30 am and 4:30 pm Monday through Friday**

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Please type or print clearly. Complete this form, sign in **blue** ink, and date where indicated. Thoroughly review and submit to the CFSA CPR office. **Allow up to 30 calendar days** for results to be processed. Expedited requests will be considered on a case-by-case basis. **Forms will be returned** if incomplete or illegible resulting in a delayed response.

PART I: Requestor Information

Request Date		Corrected Application Re-submission Date	
Requestor Type			
☐ Court	☐ Government Agency	☐ Non-Government Organization	☐ Self (*personal use only*)
Purpose			
☐ Adoption	☐ Court Request	☐ Foster Parent Licensing	☐ Kinship Licensing
☐ Visitation	☐ Current Employee/Volunteer	☐ New Hire/Volunteer	☐ Other:

Requestor/Employer Contact Information (results cannot be mailed to a P.O. Box)			
Requestor Name (print)		Requestor Signature	
Requesting Organization			
Requestor Address			
Phone Number		Fax Number	
Preferred method to return CPR check results to the requesting organization		☐ By Mail	☐ By Fax

PART II: Applicant Information

Last Name (include suffix if applicable)	First Name	Full Middle Name (write "no middle name" if there is none)

Date of Birth (MM/DD/YYYY)	Social Security Number (or Alien Registration #)	Gender (on birth certificate)	
		☐ Male	☐ Female

Other Names Used (nicknames, alias, maiden name, previous married name, legal name change, etc.)	

Current Address (include Street #, Apt #, Quadrant if applicable)	City	State	Zip

Household Information. *List all persons living at the current address with the applicant (including students away at college).*

Name (first name, middle name, last name)	Date of Birth	Relationship to Applicant

Previous Residency Information. *List all addresses (excluding zip code) and the start and end dates, to the best of your ability.*

- Applicants for employment or volunteer purposes must include all addresses of residence and where mail was received for the last five (5) years.
- Applicants for adoption, foster care, and kinship care must provide addresses for residency, receipt of mail and employment from the age of 18. Indicate L, W or M in the first column (L = lived, W = worked, M = received mail).

L W M	Previous Address (Include Street # and Apt #)	City	State	Start – End Dates (MM/YYYY – MM/YYYY)

PART III: Applicant Consent

Pursuant to D.C. Official Code § 4-1407.01, I hereby consent and authorize the D.C. Child and Family Services Agency to provide the Requestor (noted in Part I) information concerning me that is contained in the Child Protection Register ("CPR").

Printed Name: _____

Signature: _____ **Date:** _____

Must be signed in blue ink; electronic signatures not permitted

PART IV: Certificate of Acknowledgement of the Applicant before a Notary Public

Leave this space blank for Notary seal

_____

Applicant Name
(Printed)

_____

Applicant Signature
(must be signed in the presence of a Notary)

_____

Date

Subscribed and affirmed or sworn to me, in my presence, on this _____day of _____, 20____

Signature of Notary Public: _____ in the state of, _____

My commission expires on _____/_____/_____

PART V: Self Check, CFSA Resource Parent, and CFSA Kinship Caregiver Verification

CFSA USE ONLY: Identification has been shown to me that I have deemed satisfactorily identifies the applicant:

Type of ID		ID #	
CFSA Employee Name (print)			
CFSA Employee Title (print)			
CFSA Employee Signature			