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: _____

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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)

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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

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Background Check Instructions

You will be required to complete three types of criminal background checks for employment 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 I, II, III, IV B, and V (response by mail) of the Request for a CPR Check form in this packet.
2. Submit the form to: Child and Family Services Agency
   200 I St., SE
   Washington, DC 20003

Instructions for the Federal Background Check

1. You must be fingerprinted by an accepted service to begin the Federal Background Check process. In Washington, DC you can get your fingerprints done at the address below (Monday Friday 8:30-5:30, Saturday 11-2).
   Federal Services, Inc.
   1712 I Street, NW #915
   Washington, DC 20006
   202-223-5317

   (Rosemount Center has an account with Federal Services Inc.. Please let them know you are being fingerprinted for Rosemount Center so we can be properly billed. There is no charge to you at the time of fingerprinting.)
2. They will provide you with a copy of your fingerprints. You will need to bring the copy of your fingerprints (along with an $18.00 money order payable to the U.S. Treasurer) to Human Resources.

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, on the third floor of DC Police Headquarters, Monday -Friday between the hours of 9:00am and 5:00pm.
   MPDC Headquarters
   300 Indiana Avenue, Room 1075
   Washington, DC 20001
   (202) 727- 4245
2. In order to complete the form, you must bring one of the following to DC Police Headquarters:
   - Original Government Issued Photo ID
   - 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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

☐ CFSA Contractor

_____
Agency Name

Request for a Child Protection Register Check (CPR Check)

This form may be used for either 1) an in-person request for a CPR Check (Part IV-A); 2) access to substantiated reports of child maltreatment to chief executive officers (CEO) or directors of day care centers, schools, or any public or private organization working directly with children, for the purposes of making employment decisions (Part IV-B); 3) or a child-placing agency licensed in D.C. for purposes of making placement decisions. (Part V).

INSTRUCTIONS: *Please PRINT or TYPE, filling in all requested information, and sign in the places marked "Applicant Signature."* ***Please do not use initials to represent your first or middle name****. However, if your first or middle name consists of only an initial, please indicate. A complete street address is required in addition to P.O. Box numbers.*

All in person applicants are required to present ***one*** *of the following valid photo identifications: Drivers License, State Identification Card, or Passport.*

All requests for a CPR check in accordance with Part IV-B shall attach this form, with Part I, II, III and IV-B completed, along with a written request from the CEO or director which clearly articulates the basis for the request.

All requests for a CPR check in accordance with Part V shall attach this form, with Part I, II, III and IV-B completed. Note that if this request is accompanied by consent to release the information from the CPR as required in D.C. Code §4-1407.01(1)(A) then part IV-B of this form does not need to be filled out by the applicant.

PART I: Applicant Information

NAME: _____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____
Month Day Year

Race: _____ Gender: ☐ Male ☐ Female

List **all** names ever used *(maiden, married, alias, etc.; continue on additional pages if needed)*:

Last	First	Middle
Last	First	Middle
Last	First	Middle
Last	First	Middle
Last	First	Middle

PART II: Applicant Residency List all complete addresses (exclude zip code) resided in for the past eighteen (18) years and the dates lived there. Continue on additional pages if needed.

No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency

PART III: Household Information List all persons living at the current address. Print their Name, Date of Birth, and Relationship below.

NAME (Last, First. Middle)	D.O.B	RELATIONSHIP

PART IV: Applicant Release *Use Part A for requests for an in-person CPR check. Use Part B for release of CPR check to a CEO or director of a day care center, school, or any public or private organization working directly with children, for purposes of making employment decisions. Use Part B for release of a CPR check for purposes of a child placement decision by a child-placing agency licensed in the District of Columbia.*

A. For use only if requesting a CPR check in person:

I request access to the CPR for the limited purposes to determine if my name appears in it as being responsible for the abuse or neglect of a child. I have shown identification that is satisfactory to the CFSA CPR staff listed below.

_____ _____

Applicant's Signature Date

Identification has been shown to me that I have deemed satisfactorily identifies the applicant:
Type of ID _____ *ID #* _____

_____

Signature

Name of CFSA employee (print): _____

Title: _____

B. For use only if consenting to a CPR check by either 1) a CEO or director of a day care center, school, or any public or private organization working directly with children for purposes of employment or 2) a child-placing agency licensed in the District of Columbia for purposes of placement of a child:

I consent that the information contained in the CPR (whether I am "in" or "not in") may be released to my employer/potential employer or child-placing agency. A written request from the CEO or director is attached and it states the reasons for the request. Note that instead of the below consent, the child-placing agency may attach consent for release of information previously received in compliance with D.C. Code §4-1407.01.

_____

Name of Applicant

_____ _____

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

DISTRICT OF COLUMBIA:

Subscribed and affirmed or sworn to me, in my presence,

on this _____day of _____, 20___.

Signature of Notary Public

_____

Notary Public, District of Columbia

My commission expires on ___/___/____.

PART V: Agency Information (Please review entire application before forwarding to the CFSA CPR Office). MAIL COMPLETED ORIGINAL FORM TO:

Child and Family Services Agency
200 I St., SE
Washington, DC 20003
Attn: Child Protection Register

¾ **TO BE COMPLETED BY REFERRING AGENCY REQUESTING RESPONSE VIA MAIL:**

Agency Name: _____ Phone Number: _____
Email Address (optional): _____ Cubicle/Room # (CFSA Only) _____

Address: _____ City: _____

State: _____ Zip Code: _____ Attention: _____
Last Name First Name

¾ **TO BE COMPLETED BY REFERRING AGENCY REQUESTING RESPONSE VIA FAX:**

Please fax the response to: _____
(Agency Name)

Attention: _____
(Designated Agent)

Fax Number _____

****

I UNDERSTAND THAT I WILL NOT RECEIVE AN ORIGINAL COPY IN THE MAIL IF I REQUEST A FAXED COPY. _____
(Initials)