children's
ADVOCACY CENTER
OF KENT COUNTY

Thank you for your interest in volunteering with the Children's Advocacy Center of Kent County!
If you have any questions regarding our volunteer opportunities, please contact
Angie Kowalczyk at (616) 336-5197.

Personal Information

First Name _____ Last Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Emergency Contact/Relationship _____ Emergency Contact's Phone Number _____

Where did you hear about the CAC or who referred you? _____

How many hours are you available per week? _____
Please indicate your anticipated availability between 8am and 8pm:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

*Most opportunities are during the day. However, occasional evening or weekend opportunities will be available.

Education/ Employment

College _____ Graduation Year _____

High School _____ Major and Year _____

Other _____ Area of Study _____

Most Recent Employer _____ Job Title _____

Address _____ Past or Current _____

Supervisor or Employment Reference _____ Phone Number _____

References

First Name _____ Last Name _____ Relationship _____ Phone Number _____

First Name _____ Last Name _____ Relationship _____ Phone Number _____

Volunteer Experience

Date Organization Volunteer Responsibilities

_____

_____

What do you hope to gain from your volunteer experience with the CAC?

_____

_____

Please explain any experience you have working with children:

_____

_____

Please list any strong interest, knowledge areas, hobbies or special skills that you offer as a volunteer:

_____

_____

Which volunteer position interests you? Please indicate all that apply.

□ Administrative
□ Data Entry
□ Fundraising
□ Special Events
□ Photography
□ Child care/lobby support
□ Pinterest type projects
□ KHR Prevention Support
□ Reception Desk
□ Requirement for College/University*
□ Yard Work
□ Spring/Fall Clean up
□ Outreach events
□ Other:

Name of School:

*If volunteering for a school requirement: How many hours do you need: _____ What date do your hours need to be complete: _____ Name of professor: _____

Email address of professor: _____

Have you ever been convicted of or pled no contest to a misdemeanor and/or felony? □ Yes □ No

If yes, please explain:

_____

_____

Please read the following statements carefully and sign below

I certify that the statements I have made in this application are true, complete and correct to the best of my knowledge and are made in good faith. I hereby grant the Children's Assessment Center permission to verify such information and *conduct a background check including any criminal history and contacting personal, professional, and volunteer references*. I hereby release the CAC from any and all claims arising in any way from their participation in such an inquiry and investigation.

I understand that, should I become injured while performing volunteer work at the Children's Assessment Center, I am not covered under the Center's insurance and assume full responsibility for any subsequent medical expenses. I hereby hold harmless the CAC for any injuries I may sustain while volunteering.

I have read and understand volunteer duties and responsibilities as outlined in the CAC's Volunteer Application and hereby agree to abide by them. I agree to always maintain strict confidentiality regarding all clients, families, and donors involved with the Children's Assessment Center.

_____

Volunteer's Signature Date

Please mail your completed application to
Children's Advocacy Center of Kent County * 2855 Michigan Street NE, Grand Rapids, MI 49506
Or email to akowalczyk@cac-kent.org

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AUTHORIZATION FOR BACKGROUND CHECK

Full Legal Name: _____

D.O.B:_____

Street Address: _____

City/State/Zip: _____

Driver's License Number: _____

Race:

□ Caucasian
□ African American
□ Hispanic/Latino
□ Native American
□ Asian
□ Mixed Races
□ Other

I hereby authorize permission for the Children's Advocacy Center of Kent County to conduct a yearly background check including reference and checking for any criminal history.

Signature: _____ Date: _____

*Please bring your driver's license to your interview

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Confidentiality Statement

Through your activities and duties, you may learn of or have access to protected health and financial information for clients and employees. Protected health information, for employees and clients, is defined as any information that identifies an individual (client) and describes their health status, sex, age, ethnicity, or other demographic characteristics, in any format (i.e., electronic, written, or oral). Protected health information is to be maintained in a confidential manner. All protected health information is protected by law and by the privacy policies of this practice. The intent of the laws and policies is to ensure that protected health information remains confidential, and that it is used only to provide for client care and services. Your duties, obligations and responsibilities with regard to confidentiality are described below in the form of an agreement with this practice. You are required to abide by these duties, obligations and responsibilities. Any violation will subject you to discipline, which may include termination of the volunteer agreement and legal liability from the patient and this practice.

Confidentiality Agreement - I, the undersigned, agree to the following:

1. I will use protected health information only as needed to perform my legitimate duties as a volunteer of this practice. This means, among other things, that:

    - I will only access protected health information necessary for the performance of my duties;
    - I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information, except as properly authorized by the center; and
    - I will not misuse or act carelessly with protected health information.

2. I will safeguard and will not disclose information that could provide access to protected health information by persons outside of this practice.

3. I will report activities by any person or entity that I suspect may compromise the confidentiality of protected health information. (Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.)

4. I understand that my obligations for maintaining confidentiality of protected health information maintained by this practice will continue after termination of the volunteer agreement.

5. I understand that I have no right or ownership interest in any protected health information referred to in this agreement. The center may at any time revoke my access to confidential information. At all times during and after my volunteer agreement, I will safeguard and retain the confidentiality of all protected health information.

6. I will be responsible for any misuse or wrongful disclosure of confidential information and for my failure to safeguard my means of access to confidential information. I understand that my failure to comply with this agreement may also result in my loss of the volunteer agreement and legal liability.

7. All Center communications and Center business are **strictly confidential** and must be treated as such by all employees, volunteers, and service providers. No one shall divulge confidential Center business including, but not limited to, files, case records, referrals, the identity of patients, clients or alleged perpetrators, Board of Directors' information, funding sources and financial status, to any person other than Center staff, assigned service providers or members of the Board of Directors. No staff member or volunteer may speak to the media without the prior approval of the Executive Director.

_____

Name (Please Print)

_____

Signature Date