



STAR

Volunteer Community

Support - Time & Talent - Advocacy - Resources

United Cerebral Palsy of San Diego County Volunteer/Intern Information

All Information will be kept confidential

_____ Date

_____ Last Name _____ First Name _____ Middle Initial

_____ Mailing Address (Number, Street, City and Zip Code)

_____ Home Phone _____ Alternate Phone

_____ Emergency Contact – Name, Phone # and relationship

Do you require any special accommodations to assist your volunteer work?
_____ Yes _____ No

If yes, what? _____

Do you have any past or pertinent health issues that would be necessary for emergency personnel to have knowledge of? If yes, please list:

Do you hold any of the following Certifications? (Not Required)

Current CPR? _____ Yes _____ No
First Aid? _____ Yes _____ No
WSI? _____ Yes _____ No
Life Guarding _____ Yes _____ No

Other certifications/ trainings that may be helpful in this position: _____

_____.

Please list any education, paid or volunteer work experience, skills, hobbies, or interests, which might be helpful in your volunteer work.

_____.

Have you had any experience working with individuals with physical or cognitive disabilities? _____ Please describe:

_____.

Why do you wish to volunteer or intern in this program?

_____.

Please answer the following questions for your protection.

1. Have you ever been convicted of an offense other than the following:
 - A. Minor traffic violations for which the fine was \$75 or less; or
 - B. Any offense that was finally settled in a juvenile court or under welfare youth offender law._____ Yes _____ No

*****Offenses that fall under the above A, B need not be reported. *****

2. Has your driver's license ever been suspended or revoked?
_____ Yes _____ No

If “yes” to #1 or #2, then please provide the following information.

Date	Location	Offenses (nature of)	Disposition

Note: A Criminal Record Clearance is required to volunteer in some UCP Programs. UCP will cover the cost of these clearances.

Please indicate any other language or sign language spoken fluently:

Spoken: _____ Signed: _____

Please List two references (Name, Address and Phone Number)

Liability and Consent Waivers

Photo, Video and Confidentiality

1. I the undersigned, hereby give to United Cerebral Palsy Association it’s nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation or damages by reason thereof; (A) to take photographs, moving pictures and videotape of me and record my voice; (B) to use, publish or republish the same furtherance of it’s work with or without identification of me by name; (C) to use my name and information referring to me in conjunction therewith if UCPA so desires; and (D) in furtherance of UCP’s work, to release such photographs, moving pictures, videotapes and recordings to and authorize any newspaper,

company, or other organization to use, publish or republish the same with or without identification of me by name and to use my name and information referring in conjunction therewith if UCPA so desires.

2. I understand that the above information is voluntarily supplied. The information may be used only for UCP of San Diego purposes. I understand as a volunteer or intern I will not be paid for my services. Any information received from my references will remain confidential.

3. Also, the Individuals served by UCP are entitled to personal privacy rights. You, as a volunteer or intern may be given information about individuals on a need to know basis. This information will be given by the Program Coordinator and is not to be discussed with reference to name outside the agency under any circumstances. When discussing any program participants with a staff member, be sure to hold the conversation in private to protect confidentiality. Requests for information about program participants from other volunteers, collaborating agencies, visitors or event spectators should be referred to the program coordinator.

I, _____ understand this confidentiality policy as stated above. I promise to use information only for designated purposes, and will not disclose such information to any other person or agency unless specifically authorized by my UCP Program Coordinator.

Signature: _____ Date: _____

General Abuse Statement for Volunteers

As a volunteer or intern for UCP of San Diego, which provides services to dependent youth and adults with disabilities, section 15630 of the Welfare and Institutions Code requires that if in any course of your volunteer or intern efforts you become aware of or observe injuries or witness statements from an individual under your care or supervision which indicates or substantiates that abuse has occurred, you are required to report that information to a UCP Staff member who is, in turn, required to report that information to a protective agency or law enforcement agency immediately. You, as a volunteer or intern, may be asked to assist in the preparation and sending of a written report within 36 hours of the observation as required by law.

I certify that I have read and understand the above statement and will comply with its provisions.

Signature: _____

Volunteer or Intern Liability Waiver

In consideration of and through my involvement as a volunteer or intern with United Cerebral Palsy Association of San Diego County, I acknowledge and agree that:

1. I risk bodily injury, including paralysis, dismemberment, death, as well as loss of or damage to property;
2. I knowingly and freely assume all such risk; and,
3. I for myself, and on behalf of my heirs, assigns and next of kin, hereby release hold harmless and promise not to sue the _____, United Cerebral Palsy Association of San Diego County (local program, or employees) with respect to any and all such injury, paralysis, dismemberment, death, and/or loss or damage (except that which is resultant of gross negligence and /or willful or wanton misconduct.)

Signature: _____ Date: _____

This is to certify that as parent/Guardian of this participant, I do consent to his/her release of the United Cerebral Palsy Association of San Diego County (local program and Toby Wells YMCA) from any and all liabilities incident to his/her involvement as a participant for United Cerebral Palsy of San Diego County.

Parent/Guardian signature: _____ Date: _____

Volunteer/Intern Insurance

As a volunteer or intern at UCP of San Diego you will be covered under our Volunteer Accidental Medical Insurance when you are under the direction of and within the scope of duties assigned to you by the agency. For more information, please contact your Program Coordinator or Human Resources at 858 571-7803. For student interns, please consult your school regarding insurance available.

Dismissal Policy

I understand at UCP of San Diego, my services can be terminated at any time at the sole discretion of UCP, with or without notice and with or without cause.

Signature: _____

Date: _____

Revised: 4/2009