Marklund
RISING ABOVE LIMITATIONS

VOLUNTEER APPLICATION

Last Name	First Name	Middle Initial

☐ Mr. ☐ Ms. ☐ Mrs.

☐ I prefer to be called: _____

If volunteering with a group, group name:

Street Address	City

State	Zip Code	E-mail

Home Phone	Business Phone	Cell Phone

Where would you like to Volunteer?

- ☐ Marklund Children's Home– Bloomingdale
- ☐ Marklund Day School– Bloomingdale
- ☐ Marklund Hyde Center DT Program– Geneva
- ☐ Marklund Mill Creek Residential Homes– Geneva
- ☐ Marklund Resale Shop– Wood Dale

Please add me to Marklund's mailing list so that I may receive publications such as the Care Letter, Annual Report, and notices of Special Events.

☐ Yes ☐ No

What would you like to do?

- ☐ In-House Activities (Arts & Crafts)
- ☐ Pet Therapy (Pets need to be certified)
- ☐ Summer Games
- ☐ Group Activities
- ☐ Retail at the Marklund Resale Store
- ☐ Marklund Development Department (fundraising)
- ☐ Baseball
- ☐ Community Outings
- ☐ Clerical
- ☐ Other _____

When are you available?

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

Personal Information:
Drivers License or State ID #:

_____

Are you 18 years or older? Yes No

Birthday: _____
Month/Day Year (optional)

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Employment Information:

I am ☐ Employed ☐ Student ☐ Unemployed ☐ Retired

Employer/ School	Dept.
Street Address	Occupation
City	State / Zip Code

My employer offers: ☐ A time-off program for Volunteers. ☐ A matching gift program.

☐ A donation for Volunteer hours served. ☐ Have you ever been employed by Marklund before?

If you are over the age of 55, you are eligible for the Retired Senior Service Volunteer Program. Would you like an application? ☐ Yes ☐ No

Special talents or skills you would share as a Volunteer….	Previous Volunteer experience…..
Reasons you want to become a Volunteer…..	Is there any reason you would not be able to perform any tasks requested of you during your Volunteer service? Please explain:

Have you ever been convicted of a felony? ☐ Yes ☐ No *A prior conviction does not necessarily mean that you cannot volunteer. All circumstances will be considered.*

If yes please list dates, place, court and action taken:

_____

_____

Personal Reference

Please list two people who are not related to you.

Name _____ Name _____

Phone Number _____ Phone Number _____

I understand that I am not to be compensated in any form for any of the services that I perform as a Volunteer for Marklund. I understand that some Marklund locations are required by regulation to conduct a fingerprint background check for all potential volunteers, while other locations may require non-fingerprint background checks.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Parent Signature (if under 18): _____ Date: _____

FOR OFFICE USE ONLY

Orientation _____ Start Date _____ Scheduled Day/Time _____ Site _____

Dept. _____ Name Badge Mailed _____ Veterinary Record Entered _____

Background Checks - For all Volunteers who are over the age of 18

Illinois Department of Corrections (http://www.idoc.state.il.us/subsections/so_search/default.asp)_____

Illinois State Police (http://www.isp.state.il.us/sor/frames.html) _____

Completed by _____

HANDBOOK ACKNOWLEDGEMENT

"Marklund Volunteer Handbook" has been prepared to provide you with information regarding your responsibilities and rewards. Please read it carefully and feel free to ask questions during your orientation period and as they arise during the course of your volunteering at Marklund.

I have received a copy of the "Marklund Volunteer Handbook" and have read and understand the information presented. I agree to the stated policies. This handbook does not constitute a contractual agreement between Marklund and any Volunteer; either party may initiate termination proceedings.

Marklund's General Policy and Procedure #2.5 on Suspected Abuse, Neglect or Mistreatment of a Client (pages 17-32).

Marklund's Human Resources Policy & Procedure #3.19 on Harassment (page 33).

Marklund's Human Resources Policy and Procedure #3.2.3 on Smoke –Free/Tobacco-Free Policy (page 34).

Marklund's Human Resource Policy and Procedure #3.26.1 on Personal Cell Phones (page 35).

Marklund's General Policy and Procedure #7.3.1 on Workplace Monitoring Policy (pages 36-37).

MARKLUND'S STANDARD PRECAUTIONS STATEMENT (page 16).

I understand, as a Marklund Volunteer, that I am expected to use standard precautions at all times when performing my volunteer duties. Failure to do so may result in:

Exposing me to all blood borne pathogens, MRSA, CMV and other air droplet/contact borne infectious diseases
Putting my health and safety in jeopardy
Termination of my volunteer duties

VOLUNTEER CONSENT TO BE PHOTOGRAPHED

For good and valuable consideration, the receipt of which is hereby acknowledged, I, or my legal representative, if I am unable to do so, hereby authorize Marklund, its legal representatives, successors and assigns, permission to copyright, use, and/or publish photographic portraits or pictures of me, still, single, multiple or moving, or in which I may be included in whole or in part, or reproductions of these photographs, in color, or otherwise made through any media for the purpose of advertising, publicity and fund-raising for the benefit of Marklund.

I also give my permission to be identified by my name.

I waive any right that I may have to inspect and approve the finished product or the use to which it may be applied, which includes advertising, publicity and fund-raising for the benefit of Marklund.

I release and agree to hold harmless Marklund, its directors, agents, employees, successors and assigns from and against all claims, liability, loss or expense, including reasonable attorneys' fees, which may result from the taking and use of photographs.

Printed Name:_____

Signed:_____Date:_____

Policies/Statements are in the Volunteer Handbook

CONFIDENTIALITY/PRIVACY RULE (HIPAA)

"There are three major purposes included in the regulation regarding confidentiality and privacy". (1) To protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; (2) to improve the quality of health care in the U.S. by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care; and (3) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals".

December 2000 preamble

Summarizing: **HIPAA** is the Health Insurance Portability and Accountability Act. It was passed by Congress in 1996 and requires the Department of Health and Human Services to establish standards and requirements for the electronic transmission of health information. The purposes are to promote uniformity in electronic data interchange (EDI) of health information and to ensure the confidentiality of health information.

HIPAA and confidentiality regulations have been explained to me and I have read and understand how they apply for clients, clients' health records and history, and employment and volunteer records. If I am the leader of a group of volunteers, I agree to take reasonable and appropriate actions to advise all members of the group the absolute need for confidentiality and the need to adhere to all regulations of HIPAA.

I also understand that failure to follow HIPAA regulations may result in criminal prosecution and that I may be fined amounts varying from $100.00 for minor offenses up to $25,000 and prison for major violations.

Signature:_____Date:_____

Printed Name: _____

CONFIDENTIALITY & HIPAA/EMPLOYMENT AND VOLUNTEER
Rev. 03/12/03
02/10/05
02/25/05

VOLUNTEER
RELEASE
AND
WAIVER OF LIABILITY

This Release and Waiver of Liability (the "Release") executed on the day and year written below, by the volunteer shown below (the "Volunteer") in favor of Marklund Children's Home and its affiliates (collectively, "Marklund Children's Home"). The Volunteer desires to work as a volunteer for Marklund Children's Home and engage in the activities related to being a volunteer (the "Activities").

The Volunteer hereby, freely, voluntarily, and without duress executes this Release under the following terms:

The Volunteer agrees to participate in the activities and at his/her own risk. The Volunteer affirmatively states that he/she does not suffer from any type of ailment, illness or disorder that affects or may affect the undersigned's ability to participate in any services or activities.

The Volunteer hereby agrees to release, hold harmless, indemnify and defend, and does in fact hereby release and hold harmless Marklund Children's Home, its directors, officers, contractors, agents and employees from and against any liabilities, damages, and claims, of any nature whatsoever, arising from, related to or in connection with any activities.

Any and all questions or concerns shall be brought to the attention of the Volunteer Manager or designee prior to participating in the services or activities or signing of this Agreement. The Marklund Children's Home reserves the right to deny participation to any person for any reason whatsoever.

This Waiver of Liability and Hold Harmless Agreement shall be governed by the laws of the State of Illinois and jurisdiction shall be in the Counties of Dupage and Kane, State of Illinois. The invalidity or unenforceability of any of the provisions hereof shall not affect the validity or enforceability of the remaining provisions of this Release.

The Volunteer must complete this waiver and return it to the Volunteer Manager or designee in person or via mail, email or fax at 630-593-5501 prior to participation in, or providing any services or activities.

By signing below, the Volunteer has read and understands the waiver as described above.

---------- _____

Printed Name of Volunteer and group represented (if applicable)

_____

Signature of Volunteer (and guardian if under 18 years of age) Date

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AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

This authorization and consent for release of personal information acknowledges that Capital Security & Investigations, Inc. and/or it's agents may conduct investigations. These might include, but are not limited to, searches of criminal history on local, state, or federal agencies. In addition, I release and discharge the company and its agents and associates to the full extent permitted by law from any claims, damages, losses, liabilities, cost, expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting this information. I understand that this notice will apply to any future update reports that may be requested and is valid for up to one year from the date posted on this release form. After reading this document, I fully understand its complete contents and I authorize the Background Check. **Capital FAX 847-524-0711**

Print Name

Signature **Today's Date**

Birth Date :

				1	9		
Month		Day		Year			

Social Security Number :

			-			-				

Current Address (please print) :

Street

City **State** ZIP

Previous Address (if residency at current address is less than two years):

Street

City **State** ZIP