Submit via Email

DOUGLAS COUNTY DEPARTMENT OF YOUTH SERVICES
VOLUNTEER ORIENTATION FORM

VOLUNTEER'S NAME			
ADDRESS			
PHONE			
BIRTH DATE			
SOCIAL SECURITY NUMBER			
START DATE			
POSITION/TITLE			
VOLUNTEER LOCATION	330 Industrial Lane Lawrence, Kansas		
JOB DESCRIPTION			
NAME SENT TO KDHE		DATE:	
HEALTH CERTIFICATE			
TB TEST			
	Initials	Initials	Date Completed
ABUSE AND NEGLECT REPORTING PROCEDURE			
DCYS DAY SCHOOL OR RESIDENT MANUAL PROVIDED			
DRUG FREE WORK PLACE			
CONFIDENTIALITY AGREEMENT			
EMERGENCY PROCEDURES			
TRAINING RECORD REVIEWED BY:			
Licensing Worker:			
HAVE VOLUNTEER COMPLETE THIS FORM AND LEAVE IT AT THE FACILITY			

DOUGLAS COUNTY DEPARTMENT OF YOUTH SERVICES
VOLUNTEER APPLICATION

Date of Application

PERSONAL INFORMATION				
Name:				
(First)	(Middle)	(Last)		Home Telephone Number
Home Address:				
(Street)	(City)	(State)	(Zip)	How Long?
Previous Address:				
(Street)	(City)	(State)	(Zip)	How Long?
SS#	Date of Birth		Place of Birth	
Type of volunteer service: ☐ Tutor ☐ Chaplain ☐ Intern ☐ Other:				
Are you currently employed? ☐ YES ☐ NO				
May we contact your present employer? ☐ YES ☐ NO				
Are you over 18 years old? ☐ YES ☐ NO				
Are you capable of performing with or without reasonable accommodations, the essential functions of the job for which you have applied? ☐ YES ☐ NO				
Are you a U.S. citizen or are you authorized by the INS to work in this country? ☐ YES ☐ NO				
Have you ever been convicted of a felony? *Conviction will not necessarily disqualify an applicant.* ☐ YES ☐ NO				
Do you have a valid Kansas driver's license? ☐ YES ☐ NO				

Driver's license Number:	Class of CDL Designation:	On what date would you be available to begin?

EDUCATION AND SPECIAL SKILLS

EDUCATION	NAME & LOCATION OF SCHOOL	YEAR GRADUATED	MAJOR	DIPLOMA / DEGREE
High School				
College/University				
College/University				
Other Training/Education				
Are you currently a student? ☐ YES ☐ NO If yes, How many hours?				

EMPLOYMENT EXPERIENCE

Please list your present or last job or current volunteer activities.

Employer	Dates Employed		Work Performed
	From	To	
Address			
Telephone Number(s)	Hourly Rate/Salary		
	Starting	Final	
Job Title Supervisor			
Reason for Leaving			

DOUGLAS COUNTY DEPARTMENT
OF
YOUTH SERVICES

Abuse/Neglect Orientation Form

I, _____ have read the provisions of Douglas County Youth Services with respect to my responsibility for reporting of suspected child abuse/neglect and sexual abuse/sexual exploitation and discussed it with

_____
(Administrator/designee)

I understand my responsibility for reporting the incidents of suspected abuse/neglect and sexual abuse/neglect exploitation. I understand the responsibilities outlined in the volunteer manual of Douglas County Youth Services.

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Confidentiality Agreement

I understand and agree that in the performance of my duties as a volunteer at Douglas County Department of Youth Services, I must hold in strictest confidence any observations I may make or hear regarding clients, client families, or staff.

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Security Procedure Agreement

I, _____ have received, read, understand and agree to abide by the provisions of the Douglas County Department of Youth Services Volunteer Conduct and Security Procedures outlined in the volunteer manual.

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DRUG AND ALCOHOL USE AGREEMENT

I, _____, have read the Douglas County Department of Youth Services Volunteer Manual and agree to abide by the conduct rules pertaining to the use of drug and/or alcohol as is outlined in the manual.

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DOUGLAS COUNTY DEPARTMENT
OF YOUTH SERVICES
VOLUNTEER AGREEMENT

The intent of the agreement is to assure you both of our deep appreciation of your services and to indicate our commitment to do the very best we can to make your volunteer experience here a productive and rewarding one.

I. DOUGLAS COUNTY DEPARTMENT OF YOUTH SERVICES

The DOUGLAS COUNTY DEPARTMENT OF YOUTH SERVICES agrees to accept the services of _____ beginning_____, and we commit to the following:

1. To provide adequate information, training, and assistance for the volunteer to be able to meet the responsibilities of their position.

2. To ensure diligent supervisory aid to the volunteer and to provide feedback on performance.

3. To respect the skills, dignity and individual needs of the volunteer, and to do our best to adjust to these individual requirements.

4. To be receptive to any comments from the volunteer regarding ways in which we might mutually better accomplish our respective tasks.

5. To treat the volunteer as an equal partner with agency staff, jointly responsible for completion of the agency mission.

II. VOLUNTEER

I, _____, agree to serve as a volunteer and commit to the following:

1. To perform my volunteer duties to the best of my ability.

2. To adhere to agency security procedures, mandatory reporting requirements and confidentiality of agency and client information.

3. To meet time and duty commitments, or to provide adequate notice so that alternate arrangements can be made.

4. To adhere to the agency's dress code as described in the orientation manual.

5. I agree not to be under the influence of drugs or alcohol as described in the Volunteer Manual.

III. AGREED TO:

Volunteer Signature _____ Date _____

Witness Signature _____ Date_____

DOUGLAS COUNTY DEPARTMENT
OF
YOUTH SERVICES

VOLUNTEER EVALUATION

VOLUNTEER: _____ ORGANIZATION: _____

POSITION: ☐ INTERN ☐ CHAPLAIN ☐ VOLUNTEER ☐ Other:

The evaluation of the volunteer's performance will be completed by the Program Coordinator. Volunteers will be evaluated after the initial month of volunteering and annually thereafter.

PERFORMANCE ISSUE TO BE RATED	NEEDS IMPROVEMENT	GOOD	EXCELLENT
QUALITY OF WORK	☐	☐	☐
DEPENDABILITY	☐	☐	☐
JOB KNOWLEDGE	☐	☐	☐
INITIATIVE	☐	☐	☐
COMMUNICATION	☐	☐	☐
WORK RELATIONSHIPS	☐	☐	☐
JUDGEMENT/DECISION MAKING	☐	☐	☐
SECURITY	☐	☐	☐

EVALUATOR COMMENTS:

Evaluator Signature: *Date:*

AUTHORIZATION TO RELEASE INFORMATION
DOUGLAS COUNTY KANSAS

It is Douglas County policy to conduct an investigation of the criminal history record history on employees, volunteers, and final candidates for positions that perform duties within the offices of criminal justice agencies. This release form will not be considered to be part of the employment application and will be filed separately from the application. The information this form contains will not be used to make the employment decision, except in the case of refusal to authorize the investigation.

I hereby request and authorize Douglas County to conduct a criminal investigation and driving record investigation using the information I have provided below. I release Douglas County, its officers, employees, successors, and assigns from any liability that may result from the conduct of such investigation. In order to facilitate the investigation, I willingly provide the following information:

Name: _____

Date of Birth: _____ Race: _____

Driver's License: _____ State: _____

Social Security Number: _____

Current Address: _____

Maiden Name (If applicable): _____

Telephone: _____ Position: _____

_____ _____

Applicant's Signature Date

After completing this form, please insert the form in the envelope provided. Seal and return it to the Department of Youth Services.

For Department Use Only	
Department	Youth Services
Position	Volunteer
CRI Code	C
Agency ORI	KS023013C
Authorization	

Security Awareness Acknowledgment

In the carrying out of this agency's mission, sensitive information is collected that includes, but is not limited to:

Criminal Justice Information, which consists of Criminal History Record Information (CHRI) and Personally Identifiable Information (PII) which can be used to distinguish or trace an individual's identity, such as name, social security number, or biometric records, alone or when combined with other personal or identifying information which is linkable to a specific individual, such as date and place of birth, or mother's maiden name.

Other sensitive information related to the agency's operations include investigations, security procedures, operational plans, human resource, and financial records, etc.

Your authorizations to access this agencies non-public facilities, information systems, and records is based on the concepts of "need to know" and "Least privilege". That is access is determined by what your job's role(s) and functionalities are within the agency.

It is the intent of the agency to provide you with access to the resources you need to perform your role's assigned tasks. **It is not in the interest of the agency or personnel to attempt access to physical areas, media, information systems, etc. beyond that needed for your role.**

It is EVERYONE's responsibility to ensure the protection of information used in the operations of this agency. Any sensitive information, whether on an official agency report, computer screen, printout, storage device or media, etc. must be protected.

All personnel granted unescorted access to the facilities and information systems where sensitive information is processed must be aware of security principals relative to their level of access to include but not limited to agency procedures for reporting suspicious activities and physical anomalies.

Your signature below certifies that you:

1) ***Have completed awareness training based on your agency roles and responsibilities.***
2) ***Are aware of agency security standards and procedures and agree to abide by them.***
3) ***Understand that attempts to circumvent controls to prevent unauthorized access, or the disclosure of any information seen, heard, or otherwise obtained through your association with this agency to anyone outside of this agency is prohibited except when authorized by appropriate agency management as necessary for the administration of criminal justice or for criminal justice agency employment.***
4) ***Violation of agency policies and procedures and misuse or disclosure of CJI and other sensitive information may result in disciplinary action, including immediate dismissal, civil and criminal penalties including significant fines and confinement as provided in KSA 22-4707(c); 28 CFR 20.25, 28 CFR 85.5, and other federal and state laws and regulations.***

Associate Signature	Date
Printed Name	Agency Name

FCL. 009
Rev. 01/21

Kansas Department for Children and Families
Foster Care Licensing and Background Checks Division
PO BOX 1424 • Topeka, KS 66601-1424
500 SW Van Buren St • 2nd Floor • Topeka, KS 66603
Fax: (785) 296-8609
Website: http://www.dcf.ks.gov

Kansas
Department for Children and Families

CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Name of the facility (exactly as stated on the license) _____ License # _____

330 Industrial Ln

Street Address _____ City _____ Zip Code _____ County _____

Check type of child care facility:

- ☐ Attendant Care Facility
- ☐ Detention Center
- ☐ Family Foster Home
- ☐ Group Boarding Home
- ☐ Staff Secure Facility
- ☐ Residential Center
- ☐ Secure Residential Treatment Facility
- ☐ Secure Care Center
- ☐ Juvenile Crisis Intervention Center

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.

	Yes	No
1. Do you see a physician regularly for any health condition?	☐	☐
2. Are you taking any medication regularly?	☐	☐
3. Have you had any surgery in the past 3 years?	☐	☐
4. Do you have any handicapping conditions which might interfere with the care of children?	☐	☐

5. Do you have any chronic illness conditions such as:

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Cancer	☐	☐	Alcoholism	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Convulsions	☐	☐	Liver Disease	☐	☐
Lung Disease	☐	☐	Mental Illness	☐	☐	Other	☐	☐

If Other, Describe:

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ _____
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**