



2644 S. Sherwood Forest Blvd., Suite 122
Baton Rouge, LA 70816

Dear Prospective Summer 2009 Camp Staff,

Thank you for your interest in sharing your experience and unique skills working with children with diabetes at ADA Camp Victory. Camp Victory is organized and funded by the American Diabetes Association in partnership with the Lions of Louisiana. We are currently recruiting persons to join our Camp team in counseling, program and medical positions.

Persons serving as Camp Staff will arrive at Camp on July 11, 2009 (session 1) and July 18, 2009 (session 2). Camp will end for staff on July 18, 2009 (session 1) and July 25, 2009 (session 2) unless otherwise scheduled. Campers will arrive on July 12, 2009 (session 1) and July 19, 2009 (session 2). Orientation for new and returning Camp team members will be held in June 2009 (exact date TBA).

Our goal is an enjoyable and safe week for both the campers in our care and the Camp Staff. To achieve this goal, Camp Staff members must read all pre-camp correspondence and attend orientation and information sessions to better understand ADA camp policies and procedures.

Please read the following information carefully. If you want to join our team, you must complete and return all forms **no later than May 1, 2009**. In accordance with American Camp Association accreditation standards, as well as local, state, and federal laws, you cannot be allowed on Camp property if your paperwork is incomplete. Please be advised that reference checks and employment verification are conducted for all persons who have not previously served as members of the Camp team. Background searches will be done on all Camp team members. Persons are selected to be part of the Camp team based on their experience and unique skills and expertise. Camp team member selection is contingent upon timely receipt of all paperwork, satisfactory background clearances AND the number, age and gender of children attending camp.

Complete, Sign, Date & Return the Following Forms to:

AMERICAN DIABETES ASSOCIATION
2644 S. SHERWOOD FOREST BLVD., SUITE 122
BATON ROUGE, LA 70816

- ✓ Camp Staff Application
- ✓ Code of Ethics
- ✓ Confidentiality Form

If you have any questions, please call Lori Koonce at 225-216-3980 x6079, 888-DIABETES x6079 or at LKoonce@diabetes.org.

Sincerely

A handwritten signature in black ink that reads "Lori A. Koonce". The signature is written in a cursive, flowing style.

Camp Coordinator
Camp Victory
A program of the American Diabetes Association

Please return to:
Lori Koonce, Camp Coordinator
American Diabetes Association
2644 S. Sherwood Forest Blvd, Ste. 122
Baton Rouge, LA 70816
Or Fax to:
225-295-7005



Session You Would Like to Attend:
_____ **Session 1 July 12-18 (ages 6-11)**
_____ **Session 2 July 19-25 (ages 11-14)**
_____ **Other: From _____ to _____**

ALL FORMS DUE BY MAY 1, 2009

T-Shirt Size _____

**CAMP STAFF APPLICATION
NEW MEDICAL STAFF**
Please print or type

Name: _____
Last First Middle Initial Nickname

Home Address:

Street Address

City, State, Zip Code Email: _____

School/Other Address: (if different from above)

Street Address

City, State, Zip Code Email: _____

Mail should be sent to: (Check One) Home Address School/Other Address

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Business Phone: (_____) _____

Are you at least 18 years of age? YES ___ NO* ___, if not state your age _____, DOB: _____

***Camp Staff under the age of 18 must attach a copy of their valid work permit and a note signed by their parent or guardian verifying their age. Persons under the age of 18 may not serve as Camp Counselors.**

Do you have any physical or mental disabilities that might prevent you from performing the essential functions of the position for which you are applying? YES ___ NO ___

If YES, do you have specific suggestions as to how we could accommodate your mental or physical disability?

What type of Camp position are you seeking?

- | | | |
|---|---|--|
| <input type="checkbox"/> Medical Director | <input type="checkbox"/> Staff Nurse | <input type="checkbox"/> Dietetic Intern |
| <input type="checkbox"/> Staff Physician | <input type="checkbox"/> Nutrition Director | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Head Nurse | <input type="checkbox"/> Staff Dietitian | <input type="checkbox"/> Other_____ |

Are you available to work at Camp Victory _____Full Session _____Partial Session

If part time, please list exact dates: _____

LICENSURE:

What license(s) do you hold? _____

What states are you licensed in? _____

List additional professional credentials or certificates that you hold:

Note: Attach copies of current certification, licensure, or training (standard first aid, CPR, emergency water safety, lifeguard training, etc.) you hold that you believe would be useful to you in the position for which you are applying.

Has your license ever been revoked? YES _____ NO _____

If YES, please explain:

Have you ever been accused of, convicted of, or had deferred adjudication of medical malpractice?
YES ___NO___

If YES, please explain:

Do you have malpractice insurance covering your service at Camp? YES _____ NO_____

Please list your specific experience working with children with diabetes:

Past Two Years Employment: Place an X in front of any employer you do not want contacted.

Dates	(1)	(2)
Employer		
Address		
Supervisor		
Phone #		
Position Held		
Reason For Leaving		

Dates	(3)	(4)
Employer		
Address		
Supervisor		
Phone #		
Position Held		
Reason For Leaving		

References: List three (3) persons not related to you who have knowledge of your character, experience, and ability.

Name	(1)	(2)	(3)
Address			
Day Time Phone (include area code)			

What six words best describe the real you?

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

What contributions do you think you can make in the lives of children with diabetes while at Camp?

What would you personally most like to accomplish at ADA Camp Victory this summer?

How do you see yourself accomplishing this?

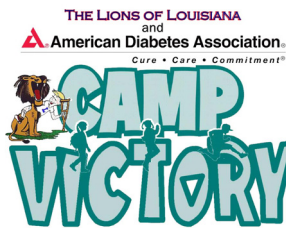
What personal knowledge or experience do you have with the management of diabetes in children?

How did you hear about ADA Camp Victory? _____

By signing below, I am indicating that I have completed this form as honestly as possible.

Signature

Date



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Camp Staff Code of Ethics

This document should be read, signed and returned by all Camp staff – paid and unpaid.

Protection of Campers/Staff

- Campers are not to be left alone without the supervision of at least two adults at any time. Proper supervision may prevent potential injury and abuse.
- Camp personnel should never be alone with campers or an individual camper.
- Camp personnel will not abuse campers including:
 - Physical abuse, e.g.,: strike, spank, shake, slap
 - Verbal abuse, e.g.,: humiliate, degrade, threaten, use profanity
 - Sexual abuse: e.g., inappropriate touching, or display
 - Mental abuse: e.g., hazing, negative manipulation, teasing or bullying
- Camp personnel will report any suspicions of abuse or neglect to the appropriate Camp leadership (Camp Director or Medical Director) immediately in compliance with state reporting regulations.
- Camp personnel will use positive guidance techniques, including redirection, anticipation, elimination of potential problems, positive reinforcement, support and encouragement, rather than competition, comparison, criticism, or humiliating discipline techniques.
- Camp personnel will report any incident or accident immediately to the Camp Director and Medical Director.
- Camp personnel will not abuse, steal from, or show disrespect to their fellow staff, campers, or Camp/personal property.
- Camp personnel will treat with confidence and respect the personal information they have learned from or about campers, subject to the policies on reporting abuse and neglect.

Conduct with Campers

- Camp personnel will portray a positive role model for campers, including but not limited to, maintaining attitudes of respect, loyalty, patience, honesty, courtesy, tact, and maturity.
- Camp personnel will not use profanity or discuss adult subject matter in the presence of campers.

Conduct with Campers (continued)

- Camp personnel must be willing and prepared to assist campers in meeting daily personal needs.
- Camp personnel must accommodate and be sensitive to the developmental differences and abilities of individual campers.
- Camp personnel will not offer to or accept gifts of goods or money from campers or their families.
- Camp personnel will not initiate social contact with campers outside of the Camp session. If contacted by a camper, the staff person will inform the ADA staff person responsible for Camp immediately.
- Camp personnel will treat campers of all ethnic, religious, and cultural backgrounds with respect and consideration

Other Guidelines or Restrictions

- Camp personnel will dress appropriately for Camp (guidelines will be discussed during staff training).
- Camp personnel will not use, possess, or be under the influence of alcohol or illegal drugs while at Camp or Camp training events.
- Camp personnel are prohibited from having firearms or other weapons while at Camp.
- Camp personnel will comply with the outlined activities and expectations of their defined jobs at Camp and participate in all required activities prior to Camp (i.e., camp training).
- Camp personnel will adhere to the outlined camp policies, procedures, and standards.
- Camp personnel will agree to all criminal and other background check information requested of them and must meet qualification standards established by the Camp.

I understand and agree to adhere to all expectations and rules established by the Camp and the American Diabetes Association, as explained above. I understand that failure to comply may result in dismissal.

Signature: _____

Date: _____

If Camp staff member is under the age of 18 the signature of his/her parent or guardian must also be provided below:

Signature: _____

Date: _____



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Confidentiality Agreement

The following relates to the access and use of Personal Health Information under the Health Insurance Portability and Accountability Act (HIPAA) by ADA Camp Victory Staff and Volunteers.

I, _____, understand that I will have access to and will use personal health information (PHI) of campers, fellow staff members and volunteers, while serving at or in preparation for an ADA Camp program.

My Camp position/duties that involve PHI may include:

- Providing medical management for campers and Camp personnel to ensure their physical well being and safety.
- Providing food service and nutrition counseling for campers and Camp personnel to ensure their physical well being.
- Providing for the well being and safety of campers in the common living areas (cabins and tents) relative to co-morbidities, diabetes treatment plans, food allergies, other allergies and behavioral/psychological/social issues.
- Providing for the safety and well being of campers and Camp personnel who will participate in the Camp program.

I agree to safeguard PHI and make sure that it is not used in an unauthorized way or given to any unauthorized person or entity.

I hereby agree that I will not copy, record, disseminate, share, use or disclose any PHI beyond my Camp position/duties.

I understand that I have the right to refuse to sign this Confidentiality Agreement and that my refusal will disqualify me from serving in any capacity with the ADA Camp program that would provide access to personal health information in written, electronic or verbal form

Name of Staff Member (print)

Signature of Staff Member

Date



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CAMP STAFF YEARLY INFORMATION FORM

Please complete this form, even if you have filled out similar forms in previous years. This information is required so that the Camp leadership can provide appropriate care for you in the event of an emergency.

Camp Staff Member Name: _____

Medical Insurance Company: _____

Policy Number: _____

Name of Policy Holder: _____

In case of emergency, notify: _____

Relationship to Staff Person: _____

Home Phone: (____) _____ Daytime Phone: (____) _____

HEALTH HISTORY:

Place a checkmark by the following conditions if you have experienced them within the past 12 months.

✓	Condition	✓	Condition	Condition
	Sinusitis		Ear Infections	Ulcer or Colitis
	Fainting		Stomachaches	Anemia
	Heart Trouble		Alcohol or Drug Use	Dizziness
	Tuberculosis		Sexually Transmitted Disease	Diarrhea
	Urinary Tract Infection		Shortness of Breath	Hepatitis, Type:
	Allergies, List:		Medications, List:	Seizure Disorder, Type:
	Other: List		Other: List	Other: List

HEALTH HISTORY (CONTINUED)

Please describe any current health conditions, except for diabetes, requiring medication, treatment, special restrictions or considerations while at Camp:

Name of Primary Care Physician: _____

Phone Number of Primary Care Physician: (____) _____

Immunizations: The American Diabetes Association does not require specific immunizations for a person to work at Camp; however, you must record the date of your last Tetanus shot.

Tetanus Shot Date: ____/____/____

Check here if a tetanus shot has never been given. _____

Have you received the Hepatitis B vaccine series?

Yes Date Completed: _____ No, I have not received this series.

Very Important!!

The Department of Public Health, Division of Communicable Disease / Epidemiology in [insert local information here] does require that a Tuberculin Test or Chest X-ray must have been performed within the 12 months prior to Camp.

Date of Tuberculin Test or Chest X-ray: ____/____/____

Camp Staff with Diabetes:

Please list your type of diabetes, how your diabetes is treated; all medications used by brand, type and dosage, including oral agents, insulins & all supplies for insulin pumps (manufacturer, model #, infusion sets, etc)

Do you recognize your own low blood sugars? ____ Yes ____ No ____ Not always

Name of Physician who treats your diabetes: _____

Phone Number of Physician who treats your diabetes: (____) _____

HEALTH HISTORY (CONTINUED)

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parents of staff or person designated as emergency contact. In the event that they or I cannot respond, I hereby give my permission to the physician selected by the Camp Director and medical team to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for me as named above.

Staff Member Signature

____/____/____
Date

I authorize investigation of all statements herein and release the Camp and all others from liability in connection with same. I understand that, if employed, I will be an at-will employee. I understand that untrue, misleading, or omitted information herein may result in dismissal, regardless of the time of discovery by the Camp.

Staff Member Signature

____/____/____
Date

All statements become part of any future camp staff's personnel file. This form has been drafted to comply with federal laws. However, the American Diabetes Association assumes no responsibility or liability for use of this form.



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CAMP STAFF PHYSICAL EXAMINATION/HEALTH EVALUATION
(To be completed by a licensed physician or nurse practitioner)

The information on this form must reflect findings of a medical examination completed within 24 months prior to the Camp staff member's Camp service, beginning on [insert date Camp staff are to report to Camp].

Date of Health Examination ____/____/____

Camp Staff Member Name:

Last

First

MI

DOB ____/____/____

Sex: ____ Male ____ Female

The purpose of this examination is to determine that the individual is physically fit to engage in strenuous camp activities with children with diabetes without harm to himself/herself and does not have a contagious or infectious condition that could be conveyed to others.

✓ Indicates Satisfactory		X indicates Unsatisfactory – explain	
<input type="checkbox"/> Posture	<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears	<input type="checkbox"/> Extremities
<input type="checkbox"/> Pulse/Rhythm	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Menstrual History/Genitalia	<input type="checkbox"/> Reactions to Medication
<input type="checkbox"/> Lungs	<input type="checkbox"/> Skin	<input type="checkbox"/> Hernia	<input type="checkbox"/> Teeth
<input type="checkbox"/> Tonsils	<input type="checkbox"/> Throat	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Athlete's Foot
<input type="checkbox"/> Nose	<input type="checkbox"/> Heart	<input type="checkbox"/> Allergy	<input type="checkbox"/> Other: _____

Explanation of Unsatisfactory Findings/Other: _____

Restricting Condition & Explanation: _____



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AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

HIPAA (Health Insurance Portability and Accountability Act)

Staff Member Name: _____ Date of Birth: ____/____/____

I hereby authorize the American Diabetes Association (ADA) to release my/my child's personal health information as described below.

I further recognize that use of my photo/likeness by the ADA may lead others to conclude that I have diabetes and as such reflects Personal Health Information (PHI). The PHI may be disclosed as part of the American Diabetes Association's marketing efforts, including but not limited to, mailing list development for Camp, a brochure promoting Camp or other educational program, or fundraising events of the American Diabetes Association.

The PHI to be disclosed is limited to the following:

Staff Member's photograph or likeness

I hereby authorize the American Diabetes Association (ADA) to use my photo/likeness to promote the ADA camp program, publicize the ADA camp program, and/or fund-raise for the American Diabetes Association.

Other: (specify)

_____ To emergency medical personnel for provision of care and billing

_____ To hospital or clinic personnel for provision of care and billing

_____ To release of records back to my primary care physician and ADA Camp Medical Staff for continuation of medical care

Expiration Date: This Authorization shall expire on December 31, 2019.

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by giving ADA written notice of the revocation. I understand that any revocation will not apply to any disclosure that has already been made in reliance upon this authorization.

Right to Refuse: I understand that I have the right to refuse to sign this Authorization and that my refusal will not affect my/my child's ability to receive treatment, get payment for treatment, or attend camp.

Copies: I understand that I will be given a copy of this signed Authorization. A copy of this document is valid as an original. The original is not required to be shown.

Name of Staff Member (print)

Signature of Staff Member

Date



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Camp Staff Yearly Information Form

Please complete this form, even if you have filled out similar forms in previous years. This information is required so that the Camp leadership can provide appropriate care for you in the event of an emergency.

Camp Staff Member Name: _____

Medical Insurance Company: _____

Policy Number: _____

Name of Policy Holder: _____

In case of emergency, notify: _____

Relationship to Staff Person: _____

Home Phone: (____) _____ Daytime Phone: (____) _____

HEALTH HISTORY:

Place a checkmark by the following conditions if you have experienced them within the past 12 months.

✓	Condition	✓	Condition	Condition
	Sinusitis		Ear Infections	Ulcer or Colitis
	Fainting		Stomachaches	Anemia
	Heart Trouble		Alcohol or Drug Use	Dizziness
	Tuberculosis		Sexually Transmitted Disease	Diarrhea
	Urinary Tract Infection		Shortness of Breath	Hepatitis, Type:
	Allergies, List:		Medications, List:	Seizure Disorder, Type:
	Other: List		Other: List	Other: List

HEALTH HISTORY (CONTINUED)

Please describe any current health conditions, except for diabetes, requiring medication, treatment, special restrictions or considerations while at Camp:

Name of Primary Care Physician: _____

Phone Number of Primary Care Physician: (____) _____

Immunizations: The American Diabetes Association does not require specific immunizations for a person to work at Camp; however, you must record the date of your last Tetanus shot.

Tetanus Shot Date: ___/___/___

Check here if a tetanus shot has never been given. _____

Have you received the Hepatitis B vaccine series?

____ Yes Date Completed: _____ ____ No, I have not received this series.

Very Important!!

The Department of Public Health, Division of Communicable Disease / Epidemiology in [insert local information here] does require that a Tuberculin Test or Chest X-ray must have been performed within the 12 months prior to Camp.

Date of Tuberculin Test or Chest X-ray: ___/___/___

Camp Staff with Diabetes:

Please list your type of diabetes, how your diabetes is treated; all medications used by brand, type and dosage, including oral agents, insulins & all supplies for insulin pumps (manufacturer, model #, infusion sets, etc)

Do you recognize your own low blood sugars? ____ Yes ____ No ____ Not always

Name of Physician who treats your diabetes: _____

Phone Number of Physician who treats your diabetes: (____) _____

HEALTH HISTORY (CONTINUED)

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parents of staff or person designated as emergency contact. In the event that they or I cannot respond, I hereby give my permission to the physician selected by the Camp Director and medical team to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for me as named above.

Staff Member Signature

____/____/____
Date

I authorize investigation of all statements herein and release the Camp and all others from liability in connection with same. I understand that, if employed, I will be an at-will employee. I understand that untrue, misleading, or omitted information herein may result in dismissal, regardless of the time of discovery by the Camp.

Staff Member Signature

____/____/____
Date

All statements become part of any future camp staff's personnel file. This form has been drafted to comply with federal laws. However, the American Diabetes Association assumes no responsibility or liability for use of this form.

Check the communicable diseases below that the staff member has been exposed to within the past 2 years:

- Tuberculosis
- Measles
- Whooping Cough
- Polio
- Rheumatic Fever
- Diphtheria
- Chicken Pox
- Hepatitis
- Small Pox
- Type: _____

Recommendation regarding staff member/patient:

<input type="checkbox"/> Full activity	<input type="checkbox"/> Restricted activity	<input type="checkbox"/> No heavy lifting
--	--	---

Comments: _____

Print Name of Examining Physician: _____

Signature of Examining Physician: _____

Date: ____/____/____

Phone #: (____) ____ - _____

Address: _____



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AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION
 HIPAA (Health Insurance Portability and Accountability Act)

Staff Member Name: _____ Date of Birth: ___/___/___

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The PHI to be disclosed is limited to the following:

Staff Member's photograph or likeness

I hereby authorize the American Diabetes Association (ADA) to use my photo/likeness to promote the ADA camp program, publicize the ADA camp program, and/or fund-raise for the American Diabetes Association.

Other: (specify)

- _____ To emergency medical personnel for provision of care and billing
- _____ To hospital or clinic personnel for provision of care and billing
- _____ To release of records back to my primary care physician and ADA Camp Medical Staff for continuation of medical care

Expiration Date: This Authorization shall expire on December 31, 2019.

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Copies: I understand that I will be given a copy of this signed Authorization. A copy of this document is valid as an original. The original is not required to be shown.

 Name of Staff Member (print) Signature of Staff Member Date

 Parent's/Legal Guardian's Name Parent's/Legal Guardian's Signature Date

(For Staff Members under 18)



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Hepatitis B Vaccination Record

Staff Member's Name: _____ Date: _____

Social Security Number: _____

Hepatitis B Vaccine Status: Three shot series completed Yes _____ No _____

Plans to receive series _____
Start Date

Declines Series at Present _____
(Must sign declination statement below)

Declination of Hepatitis B Vaccine Statement

I understand that, because of my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been informed that the hepatitis B vaccination series is available through my local health department. However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccine at a low fee from my local health department.

Staff Person Signature

Date

Parent or Guardian if < 18 years

Date

Witness

Date



ADA Office Must Complete Before Submitting

AD Louisiana

Check One Requester Only:

- Lori Koonce Ext. 6079
- John Guzzardo Ext. 6071

(225)216-3980

Reference – Account & Center Code(s) Check One Only: CAMP, FRN or Other Youth Event

- Camp Victory 43843-2120
- Baton Rouge FRN 43611
- New Orleans FRN 43827

Job Position – Please check the package you would like run:

- New Staff** (County Criminal Search 7-Year Scope All Listed Counties & Names, CHIPS 7-Year Scope All Listed Names)
- New Healthcare Staff** (Professional License Verification, County Criminal Search 7-Year Scope All Listed Counties & Names, CHIPS 7-Year Scope All Listed Names)
- New Driver** (Motor Vehicle Record 3-Year Scope, County Criminal Search 7-Year Scope All Listed Counties & Names, CHIPS 7-Year Scope All Listed Names)
- Returning Staff** (County Criminal Search 1-Year Scope All Counties & Names and CHIPS 1-Year Scope All Names)
- Returning Driver** (Motor Vehicle Record 1-Year Scope, County Criminal Search 1-Year Scope All Counties & Names, CHIPS 1-Year Scope All Names)

For Applicant to Complete:

ADA conducts background checks on all youth volunteers annually. This form provides ADA with your authorization to conduct one search of records related to criminal offenses and driving history. Medical license verification searches are conducted for med staff. Financial information is not within the scope of the search. Background check results are reviewed by ADA staff directly affiliated with youth programs and are held in a secure database.

Full Name (<i>Last, First, Middle</i>)		Date of Birth †		
Previous, Alias or Other Names Known By		Date(s) of Name Change(s)		
Residence Address (<i>Number & Street</i>)		City, State		Zip Code
County	Years at Current Address		Social Security Number †	
Driver's License Number *	State of Issue		Position Applied For	
Professional License Type	License Number	State of Issue	Date of Issue	Date of Expiration

If at current address less than seven years, please complete the following:

Previous Residence (<i>Number & Street</i>)	City, State & Zip Code	Dates at This Address
Previous Residence (<i>Number & Street</i>)	City, State & Zip Code	Dates at This Address
Previous Residence (<i>Number & Street</i>)	City, State & Zip Code	Dates at This Address

† Response to these questions is completely voluntary. You need not respond to have your application considered; however, without this information, we may be unable to distinguish you from another individual in the event we discover adverse information during our background investigation.

* This information will only be used in the normal course of business to obtain lawful information relating to a holder of a commercial driver's license, or to verify information provided by an applicant or employee pursuant to the Driver's Privacy Protection Act, 18 U.S.C. § 27-21 and applicable state laws.

ADA Office to FAX Completed Paperwork (all 3 pages) to EBI at: (410)486-0731 Questions or Concerns? Contact EBI Directly at: (800)324-7700 Please make sure your paperwork is filled out completely and no pages or information are missing. Failure to do so will result in your request being delayed so that that we may retrieve the information needed to process the background check.

Voluntary Disclosure Form (VDF)

All ADA personnel must complete this form each year. For all personnel under 18, the form must be signed by the staff member and a parent or guardian. Incomplete, unsigned or illegible forms will not be processed resulting in significant delays. Please be aware that a criminal conviction may not disqualify you for eligibility of employment. Non-disclosure of a criminal conviction in conjunction with various state and federal laws will disqualify you for eligibility. Complete the requested information below by printing legibly in dark ink.

Have you ever been convicted of any crime of violence against minors, including but not limited to those listed below?

Indecent assault and battery on a child under the age of 14 years of age	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indecent assault and battery on a mentally retarded person	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indecent assault and battery on a person 14 years of age or older	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rape	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rape of a child under 16 years of age with force	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Assault with intent to commit rape	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidnapping of a child under 16 years of age with intent to commit rape	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Distribution and trafficking of narcotics or other controlled substances	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Felony	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intent to commit any of the above crimes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above, please detail the circumstances and charges, including the date of incident, city and state/province: (use a separate sheet of paper if necessary)

Have you ever been adjudicated liable for civil penalties or damages involving sexual or physical abuse of children?
 Yes No **If yes, please detail the circumstances and charges, including the date of incident, city and state/province:** (use a separate sheet of paper if necessary)

Are you subject to any court order involving sexual or physical abuse of a minor, including but not limited to a domestic order or protection? Yes No **If yes, please detail the circumstances and charges, including the date of incident, city and state/province:** (use a separate sheet of paper if necessary)

Have your parental rights ever been terminated for reasons involving sexual or physical abuse of children?
 Yes No **If yes, please detail the circumstances and charges, including the date of incident, city and state/province:** (use a separate sheet of paper if necessary)

I understand that:

The ADA may deny employment to any person who answers any of the questions above in the affirmative. In applying for a position the information that I have furnished on this form is subject to verification, which may include a criminal history check and request from any central registry of child abusers. ADA may terminate employment or voluntary service of any person:

- Found to have a history of complaints of abuse of a minor and/or
- Found to have resigned, been terminated, or been asked to resign from a position, whether paid or unpaid, due to complaint(s) of sexual abuse of a minor.

Staff Member's Signature: _____

Date: _____

Signature of Parent or Guardian for staff members under 18: _____

Date: _____

NOTICE AND ACKNOWLEDGMENT
IMPORTANT— PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

NOTICE REGARDING BACKGROUND INVESTIGATION

ADA - ("the Company" or "Employer") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with employers and/or associates. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Employment Background Investigations, Inc. (EBI), P.O. Box 629, Owings Mills, MD 21117, 1-800-324-7700. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report and a Summary of Your Rights Under the Fair Credit Reporting Act. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from EBI all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report. **I am aware that my personal credit history will not be accessed or utilized as a part of this investigation.**

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, local, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information (including, but not limited to, driving and/or motor vehicle records, transcripts, grades and attendance records, employment history, salary information and references, drug and alcohol testing results) requested by EBI acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: By signing below you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW

Employer (the "Company") intends to obtain information about you from an investigative consumer reporting agency and/or a consumer credit reporting agency for employment purposes. Thus, you can expect to be the subject of "investigative consumer reports" and "consumer credit reports" obtained for employment purposes. Such reports may include information about your character, general reputation, personal characteristics and mode of living. With respect to any investigative consumer report from an investigative consumer reporting agency ("ICRA"), the Company may investigate the information contained in your employment application and other background information about you, including but not limited to obtaining a criminal record report, verifying references, work history, your social security number, your educational achievements, licensure, and certifications, your driving record, and other information about you, and interviewing people who are knowledgeable about you. The results of this report may be used as a factor in making employment decisions. The source of any investigative consumer report (as that term is defined under California law) will be Employment Background Investigations, Inc., P.O. Box 629, Owings Mills, MD 21117, 1-800-324-7700. The source of any credit report will be TransUnion P.O. Box 1000, Chester, PA 19022, 1-800-888-4213.

The Company agrees to provide you with a copy of an investigative consumer report when required to do so under California law.

Under California Civil Code section 1786.22, you are entitled to find out from an ICRA what is in the ICRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The ICRA may not charge you more than the actual copying costs for providing you with a copy of your file.
 - A summary of all information contained in the ICRA's file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
 - By requesting a copy be sent to a specified addressee by certified mail. ICRA's complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the ICRA's.
- "Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal or family history in order to verify your identity. The ICRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

Applicant
Signature: _____

Date: _____

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130 -A 600 Pennsylvania Ave. N.W., Washington, D. C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit

bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation, Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator – GIPSA Washington, DC 20250 202-720-7051

