CAMP ERIN
CATHOLIC HOSPICE
PART OF THE ELUNA NETWORK

VOLUNTEER APPLICATION

E-mail: CampErin@catholichospice.org | **Phone:** (954) 944-2709

Thank you for your interest in joining our Camp Erin Volunteer Team!

Volunteer Criteria:

- Must be at least 18 years AND graduated High School
- Must have experience working with children and/or teens
- Preferably have experience working with grief or have personal experience with grief/loss
- Must stay throughout the duration of camp program (unless otherwise discussed with Camp Manager)

Application Process:

1. Submit Volunteer Application
2. Submit Two (2) Professional Reference Forms
3. Attend MANDATORY Volunteer Training
4. Complete Virtus/Protecting God's Children Training
5. Complete Background and Drug Screenings
6. Attend all pre-camp events

CAMP DATE YOU ARE APPLYING FOR: _____

NAME:		**PREFERRED NAME/NICKNAME:**
DATE OF BIRTH:	**ETHNICITY:**	**PREFERRED CABIN:** ❑ MALE ❑ FEMALE
ADDRESS:	**CITY:**	**ZIP CODE:**
CELL PHONE:	**HOME PHONE:**	
E-MAIL:		**PREFERRED T-SHIRT SIZE:**
LANGUAGES FLUENTLY SPOKEN:	**ARE YOU AN ACTIVE, RESERVE OR NATIONAL GUARD MILITARY MEMBER OR VETERAN? IF SO, WHAT BRANCH?**	
WHY ARE YOU INTERESTED IN VOLUNTEERING WITH CAMP ERIN SOUTH FLORIDA?		
PLEASE LIST CREDENTIALS, EXPERIENCE, HOBBIES, AND SKILLS THAT MAY BE ABLE TO SHARE AS PART OF YOUR ROLE AT CAMP:		
ARE YOU A RETURNING VOLUNTEER? **(CHECK ONE)** ❑ YES ❑ NO	**IF SO, WHEN/WHERE WAS THE LAST CAMP YOU VOLUNTEERED:**	
INDICATE ANY MEDICAL/HEALTH INFORMATION THAT YOU WOULD LIKE US TO BE AWARE OF (EX. ALLERGIES, PHYSICAL LIMITATIONS, DIETARY RESTRICTIONS):		
HOW DID YOU HEAR ABOUT US?		

PLEASE LET US KNOW WHAT YOU ARE INTERESTED IN DOING AT CAMP.

I prefer to work with the following age group: ❑ Littles 6-9 ❑ Middles 10-13 ❑ Teens 14-17 ❑ Open/No Preference

Please specify any tasks that you would like to do at camp (ex. Cabin Big Buddy, Activity Facilitator, Camp Nuse, assist with logistics and/or meals, etc.):

_____

_____

_____

If needed, will you be available to assist with the supervision of campers on the bus? ❑ **YES** ❑ **NO**

***IMPORTANT: Volunteers must be able to stay throughout the ENTIRE camp, which includes staying overnight for our weekend youth camp programs (unless discussed otherwise with camp manager).**

EMERGENCY CONTACT: In case of emergency, please contact the below person.

Name: _____ **Relationship**: _____

Phone: _____ **E-mail**: _____

PROFESSIONAL REFERENCES: Please provide information of two (2) references.

Name: _____ **Relationship**: _____

Phone: _____ **E-mail**: _____

Name: _____ **Relationship**: _____

Phone: _____ **E-mail**: _____

CONFIDENTIALITY AGREEMENT: I understand that in the course of my time volunteering with Camp Erin South Florida, I may learn certain facts about volunteers, staff, campers, and families that are of a highly personal and confidential nature. Examples of such information would include medical/mental health diagnosis, treatment, finances, living arrangements, sexual orientation, family dynamics, and the like. I understand that all such information must be treated as confidential. I agree not to disclose any information to any person outside of Camp Erin South Florida. I further agree to abide by all requirements of my Camp Erin South Florida role, including all necessary training. I also certify that the information provided on this application is true, correct, and complete to the best of my knowledge.

_____ _____ _____

PRINT VOLUNTEER NAME **VOLUNTEER SIGNATURE** **DATE**

CAMP ERIN
CATHOLIC HOSPICE
PART OF THE ELUNA NETWORK

VOLUNTEER APPLICATION
REFERENCE FORM

NEW VOLUNTEERS ARE REQUIRED TO SUBMIT TWO (2) PROFESSIONAL REFERENCE FORMS. PROFESSIONAL REFERENCES MUST COMPLETE AND SUBMIT THE FORM.

NAME OF APPLICANT:_____

ABOVE APPLICANT HAS APPLIED TO SERVE AS A VOLUNTEER AT OUR BEREAVEMENT CAMP AS A:

- ❑ **CABIN BIG BUDDY:** The Cabin Big Buddies (CBB) supervise, support, and engage with campers throughout the entire camp. CBBs are required to stay overnight unless otherwise discussed with Camp Leadership.
- ❑ **GRIEF ACTIVITY FACILITATOR:** The Grief Activity Facilitator facilitates bereavement activities, such as art, dance/movement, yoga, trust/team building, etc. Facilitators must have experience facilitating activities in similar environments.
- ❑ **NURSE:** Preferably a Registered Nurse who can help assist Lead Camp Nurse with medical needs and provide break coverage.
- ❑ **LOGISTICS/OPERATIONS:** Supports with set-up and take down of camp activities and assists with overall logistics and flow of camp program.
- ❑ **CAMP ERIN ADVOCATE:** Ongoing support assisting Camp Leadership with marketing and promotions, which may include attending community resource events, and soliciting for donations and/or fundraising for camp program.

PLEASE RESPOND TO THE FOLLOWING QUESTIONS.

1. **In what capacity have you known the applicant and for how long?**

2. **Please describe the characteristics of the applicant that would make him/her an appropriate volunteer for our camp.**

3. **Please rank the applicant based on the following qualities:**

QUALITY	POOR	FAIR	GOOD	EXCELLENT	UNKNOWN
Attitude					
Attendance & Punctuality					
Initiative					
Dependability					
Ability to Follow Instructions					
Responds to Supervision					
Ability to Work with Others					
Ability to Work with Children/Teens					
Non-Judgmental					
Compassionate					
Sense of Humor					
Problem Solving Skills					
Ability to Work in Crisis					
Ability to Set Boundaries					
Overall Quality of Work					

4. **Is there anything else that you would like to share about this candidate?**

5. **Overall, do you recommend application to be a Volunteer at Camp Erin?** □ **YES** □ **NO**

NAME OF PERSON COMPLETING FORM: _____

RELATIONSHIP TO VOLUNTEER: _____

PHONE NUMBER: _____ **E-MAIL:** _____

I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PERSON COMPLETING FORM: _____ **DATE:** _____

THANK YOU FOR YOUR TIME!

Please submit completed forms to:
Camp Erin South Florida, 14875 NW 77th Avenue #100, Miami Lakes, FL 33014
Or by E-mail: CampErin@catholichospice.org

If you have any questions, please contact our Camp Erin team at (954) 944-2709.

CHECKLIST OF VOLUNTEER PAPERWORK

Camp Erin

NAME_____ **DATE**_____

NUMBER	FORM	REQUESTED	RECEIVED
	CHECK LIST		
1	APPLICATION	_____	_____
2	AHCA FORMS	_____	_____
3	FINGERPRINT QUESTIONNAIRE	_____	_____
3	DRUG TEST CONSENT	_____	_____
4	CONFIDENTIALITY & NON DISCLOSURE POLICES	_____	_____
5	CONSENT AND RELEASE AGREEMENT	_____	_____
6	DRIVER LIC & INS CARD	_____	_____
7	CONFLICT OF INTEREST	_____	_____
8	PROTECTING GODS CHILDREN	_____	_____
9	SEXUAL ABUSE POLICY	_____	_____
10	CHILD ABUSE POLICY	_____	_____

I.D. NUMBER IS _____

ALL PAPERWORK IS IN FILE AS OF _____ _____

(Date) (Signature)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

FINGERPRINT DISCLOSURE AND AUTHORIZATION FORM

Last Name: _____First Name: _____Middle Name:_____

Date of Birth: _____ Place of Birth: _____

SSN #: _____

Gender: ☐ Male ☐ Female

Race: _____ Eye Color: _____

Hair Color: _____ Height: _____

Weight: _____ Country of Citizenship: _____

Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____ E-mail:_____

_____ _____

Applicant Signature **Today's Date**

_____

Name (Print)

CONSENT FOR DRUG TEST SCREEN

Recognizing that substance abuse (including alcohol) is a detrimental problem facing society, Catholic Hospice Inc (CHI) is committed to providing a drug-free workplace for all employees and volunteers.

CHI understands employees and applicants under a physician's care may be required to use prescription drugs; however, illegal use of prescribed medications is also substance abuse and will be dealt with in the same manner as the abuse of illegal substances. The ultimate goal of this policy is to balance our respect for individual privacy with our need to keep a safe, productive, drug free environment.

As a job applicant, I freely and voluntarily agree to a urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by Catholic Hospice Inc., I understand and agree to abide by the company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

_____ _____

Applicant's Signature **Date**

_____

Name (Print)

Acknowledgment of Receipt and Understanding of Confidentiality and Non-Disclosure Policies Form

I acknowledge that I have received and read Camp Erin's confidentiality and non-disclosure policy and/or have had it explained to me. I understand that Camp Erin will not tolerate the dissemination of confidential information of any nature by an employee, volunteer, board member or third party.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report the mishandling of confidential information, in particular, the personal information related to and/or the photographs taken of any child currently or previously attending Camp Erin, as set forth in the confidentiality and non-disclosure policy.

I acknowledge that Camp Erin may terminate my service with or without cause of notice in relation to a violation or a suspected violation of this policy.

_____ _____

Applicant's Signature **Date**

_____

Name (Print)

A copy of your driver's license for the State of Florida and a copy of your current auto insurance card must be included with this application packet.

_____ Florida Driver's license included

_____ Auto Insurance card included

Resolution and Disclosure Regarding Conflict of Interest

Whereas, Catholic Hospice, Inc. (CHI) has a continuing responsibility to provide excellence in patient care to our community, at the lowest possible costs; and

Whereas, there exists between all categories of directors, officers and employees of CHI, a fiduciary relationship which carries with it a strict duty of loyalty and fidelity, and

Whereas, it is the responsibility of the directors, officers and employees of CHI, to make full disclosure of any interest on their part which might conflict with that of CHI, and

Whereas, it is deemed to be timely and appropriate to adopt a policy on Conflict of Interest for the guidance of directors, officers and employees.

Directors, officers and employees should exercise the utmost good faith in all transactions touching upon CHI and its property. They shall not use their positions or knowledge gained therefrom, directly or indirectly, so that conflict might arise between CHI's interest and the individual's personal interest; and they shall not accept gifts or gratuities, excessive or unusual, directly or indirectly, which might tend to influence judgment or actions concerning business of CHI.

All acts of directors, officers and employees shall be for the benefit of CHI in any dealings, which may affect CHI adversely.

Any contract or other transaction between CHI and one or more of its directors, officers or employees, or between CHI and any other corporation, firm, association or other entity in which one or more of CHI's officers, directors or employees, are directors, officers, employees or have a substantial financial interest, shall be void, unless each of the following conditions are met:

The relevant and material facts of such directors, officers or employee's interest in such contract or transaction are fully disclosed in good faith, and in advance, to the Board of Directors.

The interest the directors, officers or employees have, in the judgement of the Board of Directors, fully met the burden of proof that the contract or other transaction is fair and reasonable to CHI.

Each director, officer and employee shall be required to file a Conflict of Interest Statement, disclosing any interest, involvement or activity which would fall within the scope of the above policy.

A new director, officer, and employee shall file such a statement upon assumption of his/her responsibilities.

DISCLOSURE STATEMENT

I have read and am familiar with the Catholic Hospice, Inc. Resolution relating to Conflict of Interest.

☐ I have not undertaken an interest, involvement or activity, which would contravene such Resolution.

☐ I have engaged in activities that could be classified as a Conflict of Interest. A detailed explanation is attached.

_____

Signature **Date**

CAMP ERIN
CATHOLIC HOSPICE
PART OF THE ELUNA NETWORK

SEXUAL ABUSE

Acknowledgement and Understanding of Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Employee/Volunteer

Print Name

_____

Employee/Volunteer's

Signature

_____

Date: _____

Catholic Hospice
Providing comfort. Preserving dignity.
Est. 1988

Acknowledgement and Understanding of Child Abuse Policy

I acknowledge that I have received and read the child abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits child abuse. Disciplinary actions will be taken against those who are found to have committed child abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of child abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Employee/Volunteer	**Employee/Volunteer's**
Print Name	**Signature**
_____	_____

Date: _____