Dear Prospective Camp Hope ‘N’ Cope Volunteer,

Thank you for your interest in becoming a Camp Volunteer. Camp Hope ‘N’ Cope 2016 will be held on Saturday, August 20, 8:00 am thru Sunday, August 21 around 2:00 pm. Camp will be held at the Mt. Aetna Retreat Center, 21905 Mt. Aetna Road, Hagerstown, MD.

Please complete and return the attached application to Hospice of Washington County, 747 Northern Avenue, as soon as possible. To be considered as a volunteer for this year’s camp, your application must be received by Wednesday, July 27, 2016. Sorry, but no exceptions can be made.

We will be choosing the number of volunteers needed based on the number of campers selected. Male campers will be given a male volunteer, and female campers will be given a female volunteer. We hope to be serving at least twenty-five children at camp this year, needing 25 “Big Buddy” volunteers and approximately 5-7 support staff volunteers.

As a potential new Camp volunteer, you will need to attend the training session, which will be held on Wednesday, July 27, 2016 from 5:30-7:00 PM (*this meeting/screening is for new Camp Hope N Cope volunteers only). This will give us a chance to get to know you and provide an overview of the camp experience; developmental understanding of death per age ranges; rules of the camp; etc. Later that week, we will be meeting the children. After that time, we will best be able to match the campers with Big Buddies. We will notify everyone as soon as possible after this meeting.

It is often that we have many very good applicants, but because we only need a specific number of volunteers each year, some volunteers are not chosen. Please know that if you are not asked to attend Camp, it is because you have not met the criteria, or (most likely) because we have more volunteers interested than we have spaces open. If we are unable to use your
services at camp this year, please apply again next year. We would love to have you join us for a camp in the future.

Volunteers will need to be available from approximately **8:00 AM the Saturday** morning of camp weekend until **2:00 PM on Sunday**.

Volunteers will be chosen for the role of a “Big Buddy” or as Support Staff (see attached job descriptions). Please be sure to include any areas of special interest or any special talents that you feel may contribute to Camp Hope ‘N’ Cope.

If we can use your services at Camp this year, we will ask you to return to the HWC office for a second meeting to discuss the role you will play; to discuss the children who will be attending; and to get last details before Camp. This meeting will take place on **Wednesday, August 10 at 5:30 pm (*all Camp Hope N Cope volunteers, new and veteran, will attend this meeting)**. Please plan on attending this important meeting. Again, we will make every effort to notify you immediately after the first training with volunteers and after we also meet the children who will be attending.

Thank you for your support in helping to make this a rewarding experience for the children of Washington County.

Sincerely,

Cathy Campbell
Manager of Bereavement Services

and the Bereavement Team

*Please note-
You do not need to be a current HWC volunteer to volunteer for this camp.*
CAMP HOPE N COPE  VOLUNTEER APPLICATION

HEALTH HISTORY FORM

NAME__________________________________________________________

ADDRESS________________________________________________________

CITY__________________________  ZIP__________________________

PHONE NUMBER__________________________________________________

EMAIL ADDRESS__________________________________________________

HAVE YOU VOLUNTEERED AT CAMP HOPE N COPE IN PAST YEARS?____

PHYSICAL LIMITATIONS?  ___YES  ___NO   IF YES, PLEASE EXPLAIN

______________________________________________________________

HISTORY OF EMOTIONAL DISTURBANCES?  ___YES  ___NO  IF YES, PLEASE EXPLAIN

____________________________________________________________________

PERSON TO NOTIFY IN AN EMERGENCY __________________________

RELATIONSHIP ______________________

ADDRESS _________________________________________________________
DAYTIME PHONE # ____________________ EVENING PHONE # ____________________

HEALTH HISTORY (Please check those that apply)

___Allergies     ___Emotional Problems     ___Wears Contacts/Glasses
___Asthma       ___Hearing Impairment     ___Heart Disease
___Seizures      ___Physical Limitations   ___Other
___Diabetes     ___Motion Sickness

t-shirt size________________________________

Please explain any items that were checked or indicate any other useful information regarding your health:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Are you currently under a physician’s care for a medical problem?  ___YES  ___NO

Are you restricted from participating in any physical activity?  ___YES  ___NO

I know of no health reasons, other than information indicated on this form, why I should not participate in any of the Camp Hope N Cope activities.

__________________________  ______________________
Signature                     Date

Any other information you can share about yourself that would be helpful to us in determining the best fit for you?______________________________

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my participation in Camp Hope N Cope activity and I am unable to speak for myself, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp Hope N Cope professional staff and

2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

________________________________________  ______________________
Signature                                      Date

Preferred medical doctor/facility ________________________________

Address _______________________________________________________

Telephone Number __________________________

Insurance Company _____________________________________________

Policy Number ________________________________

Policyholder’s Name _____________________________________________
STATEMENT OF CONFIDENTIALITY

I understand that information regarding Hospice of Washington County, patients, their families and/or significant others and any persons receiving support or services in any capacity is privileged information for use by and with authorized persons only.

I will disclose such information only in the discharge of my assigned duties and responsibilities with Hospice or persons authorized to receive such information through the signed consent of patient, family member, or affected party.

I will not disclose any information with anyone unauthorized to receive this information. I will handle any and all paperwork and forms with proper procedure of control so that no information is accidentally observed or released to any unauthorized persons. I also understand that the casual sharing of client care information in public places or settings is inappropriate.

I further understand and agree that any violation of this policy is of such critical offense that it will justify my immediate discharge.

Print Name ___________________________________________
Signature _____________________________________________
Date ______________

VOLUNTEER RELEASE OF LIABILITY

I understand and agree that Hospice of Washington County, Board of Directors, Employees and Volunteers are released from any legal responsibility and/or liability for negligence arising out of any accidents or illnesses which occur while the volunteer listed below attends Camp Hope N Cope.

_______________________________________
Signature of Volunteer
Date

VOLUNTEER PUBLICITY PERMISSION

Upon occasion, videotaping and/or photography may occur during camp activities. This material may be used for future publicity by Hospice of Washington County and its Board of Directors. In addition, with Hospice staff permission and supervision, the news media may wish to photograph, videotape and/or interview some of the volunteers and children attending camp. Please sign below if you have no objections to being subject to this.

_______________________________________
Signature of Volunteer
Date
Job Description

BIG BUDDY

PLEASE REMEMBER, WE CAN ONLY ACCEPT A SPECIFIC NUMBER OF VOLUNTEERS, DEPENDING ON THE NUMBER OF CHILDREN WE HAVE ATTENDING CAMP. ALSO, EACH CHILD IS MATCHED UP ACCORDING TO HIS/HER GENDER. THE SELECTION OF VOLUNTEERS DEPENDS ON THE NUMBER OF EACH GENDER (CAMPERS) CHOSEN.

DESCRIPTION:

THE BIG BUDDY IS RESPONSIBLE FOR PROVIDING ONE-ON-ONE SUPPORT AND GUIDANCE TO HIS/HER LITTLE BUDDY, AS REQUESTED BY THE CAMP COMMITTEE. THE BIG BUDDY IS EXPECTED TO PARTICIPATE IN ALL WEEKEND ACTIVITIES WHILE SUPERVISING THE CHILD TO WHOM HE/SHE IS ASSIGNED.

APPLICANTS ARE CHOSEN, USING THE FOLLOWING CRITERIA:

- MUST BE 18 YEARS OLD OR OLDER
- MUST COMPLETE AND RETURN ENTIRE APPLICATION PACKET PRIOR TO THE DEADLINE ESTABLISHED
- MUST ATTEND ALL REQUIRED TRAININGS
- MUST BE AVAILABLE FOR ALL HOURS OF THE WEEKEND EXPERIENCE
- WASHINGTON COUNTY RESIDENTS ARE GIVEN FIRST CONSIDERATION
- EXPERIENCE WITH CHILDREN AND BEREAVEMENT ISSUES DESIRABLE
- MUST CONSENT TO A BACKGROUND CHECK AND AUTHORIZE HOSPICE OF WASHINGTON COUNTY TO OBTAIN THE RECORDS *
- MUST BE ABLE TO PARTICIPATE IN AND PERFORM ALL PHYSICAL AND EMOTIONAL EXERCISES

* HWC HAS THE RIGHT TO REJECT AN APPLICATION OF ONE WHO HAS RECEIVED AN UNDESIRABLE BACKGROUND CHECK

RESPONSIBILITIES WILL INCLUDE BUT NOT BE LIMITED TO:

- ADHERES TO GUIDELINES/PROCEDURES ESTABLISHED BY THE CAMP COMMITTEE, AS DISCUSSED IN TRAINING
- ADHERES TO POLICIES/PROCEDURES ESTABLISHED BY THE CAMP FACILITY

***THE MAIN ROLE OF THE CAMP VOLUNTEER IS TO PROVIDE FRIENDSHIP AND SUPPORT ONLY, NOT GRIEF THERAPY!

***AFTER CAREFUL CONSIDERATION, THE FINAL DECISION OF APPLICANTS ACCEPTED IS AT THE DISCRETION OF THE CAMP HOPE N COPE COMMITTEE.
Job Description

SUPPORT STAFF

PLEASE REMEMBER, WE CAN ONLY ACCEPT A SPECIFIC NUMBER OF VOLUNTEERS, DEPENDING ON THE NUMBER OF CHILDREN WE HAVE ATTENDING CAMP. THE SELECTION OF VOLUNTEERS DEPENDS ON THE NUMBER OF EACH GENDER (CAMPERS) CHOSEN AS WELL AS THE SIZE OF THE CAMP FACILITY (FOR PURPOSES OF ACCOMMODATIONS)

DESCRIPTION:

THE SUPPORT STAFF IS RESPONSIBLE FOR PROVIDING ASSISTANCE TO THE CAMP COMMITTEE MEMBERS AND OTHER CAMP VOLUNTEERS, AS NEEDED. THE SUPPORT STAFF IS EXPECTED TO PARTICIPATE IN ALL WEEKEND ACTIVITIES WHILE PROVIDING GAMES, ACTIVITIES, ASSISTANCE AND SUPERVISION AS NEEDED.

APPLICANTS ARE CHOSEN, USING THE FOLLOWING CRITERIA:

- MUST BE 18 YEARS OLD OR OLDER
- MUST COMPLETE AND RETURN ENTIRE APPLICATION PACKET PRIOR TO THE DEADLINE ESTABLISHED
- MUST ATTEND ALL REQUIRED TRAININGS
- MUST BE AVAILABLE FOR ALL HOURS OF THE WEEKEND EXPERIENCE
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- ADHERES TO POLICIES/PROCEDURES ESTABLISHED BY THE CAMP FACILITY

***THE MAIN ROLE OF THE CAMP VOLUNTEER IS TO PROVIDE FRIENDSHIP AND SUPPORT ONLY, NOT GRIEF THERAPY!

***AFTER CAREFUL CONSIDERATION, THE FINAL DECISION OF APPLICANTS ACCEPTED IS AT THE DISCRETION OF THE CAMP COMMIT
NOTICE/AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT
(PLEASE PRINT OR TYPE)

*Need not be completed by HWC staff or current HWC volunteers
*Needs to be completed by all Camp volunteers, new and veteran

I, the undersigned consumer, do hereby authorize HOSPICE OF WASHINGTON COUNTY, INC., by and through an independent contractor, Employment Information Service. (“EIS”), to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character and general reputation, discerned through employment and education verifications; personal references; personal interviews; my personal credit history based on reports from any credit bureau; my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to EIS, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to HOSPICE OF WASHINGTON COUNTY, INC., by and through EIS, including, but not limited to any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release HOSPICE OF WASHINGTON COUNTY, INC., EIS and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized.

I understand that this Notice/Authorization Release form shall remain in effect for the duration of my employment with Hospice of Washington County, Inc. Additionally, I give permission to investigate any incidents of workplace misconduct or criminal activity for which I am alleged to have been involved during my employment. Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application will be terminated based on any false, omitted or fraudulent information.

Signature:

__________________________

Printed Name:_______________________ Date: ______

First Middle Last

Other Names Used (alias, maiden, nickname)__________________________

YEARS USED________
Please list all addresses for the past five years.

Current Address: ____________________________________________________________

<table>
<thead>
<tr>
<th>Street /P. O. Box</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
<th>Dates</th>
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Former Address:

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<tr>
<th>Street /P. O. Box</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<th>Dates</th>
</tr>
</thead>
</table>

Social Security Number: __________________________

Daytime Telephone Number: ________________________

Driver’s License Number: _______________________ State of Issuance: __________

Date of Birth*: ___________________ Gender*________

- Have you ever been sanctioned or had your licenses suspended or revoked?
  Yes____ No____

- Are you currently under any investigation or pending charge?
  Yes____ No____