Dear Prospective DoveTales Camp Volunteer,

Thank you for your interest in becoming a DoveTales: A Camp for Grieving Children 2019 volunteer!

DoveTales will be held on Saturday, October 12, 2019 at the Cornerstone Community Church, located at 20519 Beaver Creek Road Hagerstown, MD 21740.

DoveTales designed for children (ages 6-13) who are coping with the death of a loved one. DoveTales is an educational, nurturing, and safe place for children to share their stories and to meet others who "get it." Campers will have the opportunity to learn effective and practical skills for coping with their grief. There is no cost to attend this annual event. Campers are invited to attend one camp experience, then encouraged to participate in future camp reunion events.

The full day camp event will begin at 8:30 AM and conclude at 6 PM. Group activities include sharing stories, creating lots of crafts, playing games, singing songs, enjoying a special hayride and farm animal visit, and having fun! All meals are included. Parents/guardians are invited to attend a special family dinner at 5 PM, and meet other families, learn about camp activities, and honor their loved ones.

We are requesting that volunteers commit to the following:

- Attend Training session will be held on Monday September 30, 2019 at 5:30 – 7 PM at main office of Hospice of Washington County (747 Northern Ave, Hagerstown 21742)
    - This is required volunteer training session to meet staff, review plan for the day of camp, learn about general childhood grief, and ask any questions.
- Attend DoveTales on Saturday October 12, 2019 at Cornerstone Community Church. (20519 Beaver Creek Road, Hagerstown 21740). Please note your preferences and time availability.
    - Assistance is appreciated with general set up before campers arrive, and clean up after the campers have left.

Please complete and return the attached application to the Hospice of Washington County office as soon as possible. Our office is located at 747 Northern Ave, Hagerstown MD 21742. **Your completed application must be received by *Friday, September 27, 2019* to be considered as a volunteer for this year's camp. Sorry, but no exceptions can be made.**

We will be choosing the number and roles for volunteers needed based on the number of campers selected. Volunteers will serve in the role of as Support Staff or Big Buddy (see attached job description). Please be sure to include any areas of special interest or any special talents that you feel may contribute to DoveTales.

If you have any questions or concerns, please reach out to the bereavement department at 301-791-6360 or by email Maria Reed, Bereavement Counselor, at mdreed@hospiceofwc.org. We are available Monday-Friday, 8AM -4:30 PM.

Sincerely,

The Bereavement Team

Keep this cover page for reminders and information. Return rest of the packet.

DoveTales Camp 2019: Volunteer Application

NAME:_____

ADDRESS:_____

CITY:_____ **STATE:** _____ **ZIP:**_____

PHONE NUMBER:_____

EMAIL ADDRESS: _____

HAVE YOU VOLUNTEERED AT A GRIEF CAMP (CAMP HOPE N COPE) IN THE PAST? _____
IF SO, PLEASE LIST YEARS: _____

T-SHIRT SIZE: _____
(We are designing new t-shirts this year! All campers and volunteers will receive a t-shirt.)

I AM PLANNING TO ATTEND THE FOLLOWING EVENTS:

_____**Volunteer Training Session on Monday Sept. 30, 2019 at 5:30 PM (HWC Main office)**
_____ **DoveTales Camp on Saturday October 12, 2019 8 AM – 8 PM* (Cornerstone Church)**
If you are unable to attend all day, please note specific times you are available

I AM INTERESTED IN THE FOLLOWING VOLUNTEER ROLES (may select multiple):
****Review the detailed descriptions of support staff and Big Buddy found printed later in this packet.****

_____**SUPPORT STAFF (Assistance with activity set up, supervision, and clean up)**
I am available during the following times of the day: _____**All Day (8AM - 8PM)**
_____**Morning Set Up (8 – 9 AM)**
_____**Clean Up (6 – 8 PM)**

_____ **BIG BUDDY (Assigned to a specific or group of campers to provide direct mentorship –**
******Please plan to commit to attend full day 8 AM – 6 PM****)**

_____ **CAMP NURSE (Available as needed to assist campers and volunteers in an event of a medical concern or question i.e injuries – Please note times you are available:** _____**)**

_____ **I'M AVAILABLE TO ASSIST HWC STAFF WITH SET UP WEEK BEFORE CAMP**
***May include loading and transporting materials from HWC office to Cornerstone Community Church, and set up at camp location. Note days/times you are available:**_____

I understand that all final decisions regarding volunteer acceptance is at the discretion of the DoveTales Camp for Grieving Children Committee. HWC has the right to reject an application of one who has received an undesirable background check.

The main role of Camp Volunteers is to provide mentorship and support only, not grief therapy.

_____ _____
Signature **Date**

VOLUNTEER BACKGROUND

Please describe the deaths you have experienced in your life:

Relationship	Date of Death	Cause of Death

Tell us a little bit about yourself, and why you are interested in volunteering for this Camp.

Do you have any particular hobbies or talents? Are you interested in sharing your talents during camp?

Please share any additional information that will be helpful in assisting us in matching you with a camper or particular activity.

Please share any questions or concerns you have about the camp experience:

NAME OF VOLUNTEER:_____
DOB:_____

IN CASE OF EMERGENCY:

PERSON TO NOTIFY IN AN EMERGENCY _____

RELATIONSHIP _____

ADDRESS _____

DAYTIME PHONE # _____EVENING PHONE #_____

HEALTH HISTORY FORM

DO YOU HAVE ANY PHYSICAL LIMITATIONS? ____YES ____NO
IF YES, PLEASE EXPLAIN:
_____

DO YOU HAVE ANY ALLERGIES? ____ NO ____ FOOD _____ ANIMALS ____ HAY _____ OTHER
Camp activities will include all meals (breakfast, lunch, and dinner), animal-assisted therapy experience with horses and small farm animals, and a hayride If yes, please provide details:
_____

DO YOU HAVE ANY HISTORY OF EMOTIONAL DISTURBANCES? _____YES _____NO
IF YES, PLEASE EXPLAIN: _____

HEALTH HISTORY (Please check those that apply)

___Allergies	___Mental/Emotional Difficulties	___Wears Contacts/Glasses
___Asthma	___Hearing Impairment	___Heart Disease
___Seizures	___Physical Limitations	___Other
___Diabetes	___Motion Sickness	_____

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 DoveTales Camp for Grieving Children activities.

_____ _____
Signature Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my participation in DoveTales 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 Hospice of Washington County 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 DoveTales Camp for Grieving Children.

_____ _____

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

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 ACTIVITIES WHILE SUPERVISING THE CHILD TO WHOM HE/SHE IS ASSIGNED.

Job Description SUPPORT STAFF

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 CAMP 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**
- **MUST ATTEND ALL REQUIRED TRAININGS**
- **MUST BE AVAILABLE FOR HOURS OF THE CAMP 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 ***

*** *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
ADHERES TO POLICIES/PROCEDURES ESTABLISHED BY THE CAMP FACILITY

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

*****AFTER CAREFUL CONSIDERATION, THE FINAL DECISION OF APPLICANTS ACCEPTED IS AT THE DISCRETION OF THE DOVETALES CAMP FOR GRIEVING CHILDREN COMMITTEE.**

Dove Tales
a camp for grieving children

Background Check Consent Forms: DoveTales Volunteers

Volunteer Name: _____

Are you a current HWC employee? ____ Yes ____ No

Are you a current HWC trained volunteer? ____ Yes ____ No
(under the supervision of Lindsey Anderson)

**If you selected YES because you are a current HWC employee or trained volunteer, then you do NOT need to complete and turn in the following background check forms.

**If you are NOT a current HWC staff member, then please read and complete the following forms (4).

hospice
of washington county

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Hospice of Washington County, Inc. may obtain information about you from a third-party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you and to request a copy of your report. These searches will be conducted by **TriCor Employment Screening, 110 Blaze Industrial Pkwy Suite C, Berea, OH 44017, (800) 818-5116, and https://tricorinfo.com/.** The scope of this disclosure allows the Company to obtain consumer reports now and throughout the course of your employment for an employment purpose to the extent permitted by law.

Signature: _____ Date: _____

[End of Document]
p. 1 of 1

747 Northern Avenue
Hagerstown, MD 21742

P 301-791-6360
E info@hospiceofwc.org
hospiceofwc.org

hospice
of washington county

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE 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" by Hospice of Washington County, Inc. at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize any law enforcement agency, administrator, 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 requested by **TriCor Employment Screening, 110 Blaze Industrial Pkwy Suite C, Berea, OH 44017, (800) 818-5116, and https://tricorinfo.com/** and/or Employer.

New York applicants only: Upon request, you will be informed whether or not a consumer report and/or investigative consumer report was requested by the Employer, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

New York City applicants only: You acknowledge and authorize the Employer to provide any notices required by federal, state or local law to you at the address(es) and/or email address(es) you provided to the Employer.

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

You acknowledge and authorize Hospice of Washington County, Inc. to provide any notices required by federal, state or local law to you at the email address(es) you provided to the Hospice of Washington County, Inc..

Signature: _____ Date: _____

[End of Document]

747 Northern Avenue
Hagerstown, MD 21742

P 301-791-6360
E info@hospiceofwc.org
hospiceofwc.org

hospice
of washington county

DISCLOSURE REGARDING "INVESTIGATIVE CONSUMER REPORT"

BACKGROUND INVESTIGATION

Hospice of Washington County, Inc., to which you have applied for employment, may request an investigative consumer report about you from a third party consumer reporting agency, in connection with your employment or application for employment (including independent contractor or volunteer assignments, as applicable). An "investigative consumer report" is a background report that includes information from personal interviews (except in California, where that term includes background reports with or without information obtained from personal interviews). The most common form of an investigative consumer report in connection with your employment is a reference check through personal interviews with sources such as your former employers and associates, and other information sources. The investigative consumer report may contain information concerning your character, general reputation, personal characteristics or mode of living. You may request more information about the nature and scope of an investigative consumer report, if any, by contacting the Company.

You have the right, upon written request made within a reasonable time, to request (1) whether an investigative consumer report has been obtained about you, (2) disclosure of the nature and scope of any investigative consumer report and (3) a copy of your report. These reports will be conducted by **TriCor Employment Screening, 110 Blaze Industrial Pkwy Suite C, Berea, OH 44017, (800) 818-5116, and https://tricorinfo.com/**. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of investigative consumer reports throughout the course of your employment to the extent permitted by law.

Signature: _____ Date: _____

[End of Document]
p. 1 of 1

747 Northern Avenue
Hagerstown, MD 21742

P 301-791-6360
E info@hospiceofwc.org
hospiceofwc.org

hospice
of washington county

BACKGROUND INFORMATION

Last Name_____ First _____ Middle _____

Other Names/Alias_____

Social Security* # _____ Date of Birth* _____

Driver's License # _____ State of Driver's License**_____

Present Address_____ Phone Number _____

City/State/Zip_____

Former Employer_____ Position_____ Dates of Employment _____

*This information will be used for background screening purposes only and will not be used as hiring criteria.

747 Northern Avenue
Hagerstown, MD 21742

P 301-791-6360
E info@hospiceofwc.org
hospiceofwc.org