

Pickens County Board of Disabilities and Special Needs

Volunteer Applicant Approval Process:

Name (*Please Print*): _____

OFFICE USE ONLY:

Program Assigned _____

1. HR Director/Supervisor: _____ / ____/____
2. Program Director: _____ / ____/____
3. Job Duties: _____ / ____/____
4. Executive Director: _____ / ____/____
5. Issue of Volunteer Card: _____ / ____/____

NOTE:

- A. A Background investigation will be completed after the submission of all volunteer applications from outside the agency, but not on personnel or consumers of the agency. (***SLED, DSS Abuse & Neglect Registry, Sex Offender, Human & Health Service***)
- B. The Program Director of the department the volunteer will be volunteering will provide the job duties that the volunteer will be assigned to. A list of the job duties must be turned into the Human Resources Director/Supervisor before the volunteer application is approved. Job Descriptions may be created and provided to those volunteers with long term assignments.
- C. Volunteer badges will be provided for volunteer. Only the Officers of the consumer council will have Volunteer badges with their picture.

Pickens County Board of Disabilities and Special Needs

Volunteer Application

(Please Print)

Name _____ Title _____

Organization/Address: Street or P.O. Box _____

City _____ State _____ Zip _____

Telephone: Home (_____) _____ Work (_____) _____

Fax (_____) _____ E-mail _____

Cell Phone (_____) _____ Pager (_____) _____

Social Security _____ Birth date _____

Do you have a SC Drivers License? ____yes ____no. DL # num _____

Have you ever been convicted of a felony? If yes, explain: _____

Why do you want to volunteer for PCBDSN? _____

Do you have any experience volunteering/working with people with developmental disabilities: If yes explain: _____

Do you know any employee of PCBDSN that could serve as a reference? ____yes ____no

Name _____ Position _____

Type of Volunteer Services desired: _____ Direct (with consumers)
_____ Indirect (w/o consumers)

Volunteer interests: Place a check beside all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Adopt a unit | <input type="checkbox"/> Senior Companion | <input type="checkbox"/> Pen Pal |
| <input type="checkbox"/> Arts/Crafts | <input type="checkbox"/> Chaperon, Field Trips | <input type="checkbox"/> Recreation |
| <input type="checkbox"/> Hairdressing | <input type="checkbox"/> Dancing | <input type="checkbox"/> Music |
| <input type="checkbox"/> Carpentry/Woodwork | <input type="checkbox"/> Drama | <input type="checkbox"/> Greenhouse |
| <input type="checkbox"/> Library Work | <input type="checkbox"/> Special Events | <input type="checkbox"/> Needlework/Mending |
| <input type="checkbox"/> Bicycle Repair | <input type="checkbox"/> Birthday Buddies | <input type="checkbox"/> Typing/ Clerical |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Respite Care | <input type="checkbox"/> Classroom Aide |
| <input type="checkbox"/> Community Resource | <input type="checkbox"/> Religious Ed | <input type="checkbox"/> Special Friend |
| <input type="checkbox"/> Worker | <input type="checkbox"/> Senior Companion | <input type="checkbox"/> Pen Pal |
| <input type="checkbox"/> Other (Specify below) | | |
-
-

Current or Most Recent Employment

Name of organization _____

Duration of Employment ____/____/____ to ____/____/____

Supervisor _____ Phone (____) _____

Responsibilities _____

Previous Volunteer Experience

Name of organization _____

Duration of Volunteering ____/____/____ to ____/____/____

Supervisor _____ Phone (____) _____

Responsibilities _____

Name of organization _____

Duration of Volunteering ____/____/____ to ____/____/____

Supervisor _____ Phone (____) _____

Responsibilities _____



Name of organization _____

Duration of Volunteering ____/____/____ to ____/____/____

Supervisor _____ Phone (____) _____

Responsibilities _____



THIS SECTION TO BE COMPLETED IF YOU WOULD LIKE TO VOLUNTEER FOR DIRECT SERVICES.

List 3 names of people (not relative) that can give you a reference.

1. Name _____ Phone _____

Employer ____yes ____no

2. Name _____ Phone _____

Employer ____yes ____no

3. Name _____ Phone _____

Employer ____yes ____no

In case of an emergency notify:

Name _____ Phone _____

I understand that if I would like to take an individual to my home for a visit a representative from PCBDSN must visit my home first. I consider myself to be in good physical health.

Name

Date

Pickens County Board of Disabilities and Special Needs

Volunteer Services

Acknowledgement of Confidentiality of Consumer of Individual Information:

In connection with the PCBDSN as a volunteer in Pickens County, I agree to hold all information I may have access to about consumers or individuals confidential and will not divulge any information to unauthorized persons. I understand releasing confidential information to unauthorized persons will make me subject to either civil action for the collection of monetary damages and/or suspension or dismissal.

1. Each volunteer is responsible for the strict observance of department rules and regulations and are required to report infractions thereof.
2. Abuse of individuals is strictly prohibited by SCDDSN and will result in termination for cause and/or prosecution.
3. The behavior of individuals, their limitations and family problems should not be discussed with individuals outside the department.
4. All information concerning individuals is confidential. Accessibility to individual records is OFF LIMITS to volunteers, unless obtained by special request through Administration or Service Coordinators.
5. Photographs of individuals may not be taken unless permission is obtained from the Director of the program.

Signature

Witness

Date

Pickens County Board of Disabilities and Special Needs

Fact Sheet for Volunteers

Confidentiality: Confidentiality means safeguarding sensitive or delicate information regarding individuals, their families, and the PCBDSN so that only the staff and volunteers who “need to know” particular information have access to it. Maintaining confidentiality includes sensitive information such as stool charts, seizure charts, twenty-tab folders, and special medical instructions. All posted information of a sensitive nature must have a cover sheet if it can be posted at all. Please consult with the in-charge person in your area regarding information of a sensitive nature.

Individual Rights: Individuals of the PCBDSN have all human rights that any citizen has. For example choices, dignity, and privacy are rights that we encourage and enjoy. Please consult with the service coordinator or in-charge person in your area if you have questions regarding an individual’s rights or feel that they are being withheld for any reason. An important part of our responsibilities, whether staff or volunteer, is to actively protect and promote choices and human rights initiatives for the people we serve.

Abuse Prevention: Abuse is hurting or harming a person who is receiving services. Even if the abuse does not leave an injury or mark, if you meant to hurt them, you are guilty of abuse. If you help someone abuse another person or cover up for them, you are also guilty of abuse.

The law requires you to report abuse. If you see abuse or think that a person receiving services has been abused, notify the unit supervisor or other appropriate in-charge person(s) as soon as you think something is wrong.

******Please refer to the SCDDSB Prevention Abuse brochure for eight specific definitions of abuse and additional information regarding this subject.**

Accountability: All staff and volunteers are responsible for individual accountability and must be conscious of situations where individuals may be in potential danger to themselves, to others, or when accountability may be breached. Based on the nature and degree of their disability, individuals require varying degrees of supervision as they participate in daily programs and activities. Please consult the in-charge person in your area for detailed information about the degree of supervision required for the individual(s) with whom you are working.

Fights, sexual encounters, accidents, and other undesirable or dangerous activities can often be prevented if individuals’ behaviors are appropriately monitored. Know the individuals with whom you are working in your area and what their schedules are. Also, assist any individual not under proper supervision, return the individual to his/her area, and promptly report the incident to the staff person in charge.

Infection Control: Eyes, nose, mouth, and non-intact skin are methods of transmission. All blood exposures are considered potentially infectious including undiagnosed exposures. Sources of virus transmission include blood, wound drainage, tissue, and other body fluids.

To prevent exposure, wear gloves when likely to touch body fluids and change them after each patient contact. Protective eyewear and mask are used if likely to have blood or body fluid droplets in the air. Also remember that thorough and frequent hand washing is the best method of preventing the spread of infection in addition to wearing gloves and reporting any signs of illness to the nurse or in-charge person.

*******Please refer to the Blood borne Infections brochure for additional information regarding infection control issues.**

Pickens County Board of Disabilities and Special Needs

Supplementary Application for Volunteer Service

Name: _____

Date: _____

Assignment: _____

Please read all of the following information and sign to indicate if all materials were explained and understood by you before being placed on your volunteer assignment.

I hereby authorize the PCBDSN and/or SCDDSN to obtain all information regarding my character, conduct, etc. from references listed on my application for Volunteer Services.

I further release from all liability my stated references who furnish information.

Date

Signature

The Following have been explained and are understood by me:

- 1. Confidentiality _____
- 2. Individual Rights _____
- 3. General Volunteer Guidelines _____
- 4. Liability _____
- 5. Abuse Policy _____
- 6. Accountability Requirement _____
- 7. Facts of Infection Control _____

Date

Signature

Date of Orientation

*******ALL VOLUNTEERS UNDER 18 YEARS OF AGE*******

I hereby give permission for my child/ward to be a volunteer worker at this agency.

Date

Signature

TO: SC LAW ENFORCEMENT DIVISION

RECORDS SECTION
P.O BOX 21398
COLUMBIA, SC 29221

FROM: PICKENS COUNTY BOARD OF DISABILITIES AND SPECIAL NEEDS

HUMAN RESOURCES
P.O BOX 1308
EASLEY, SC 29641

RE: RECORD CHECK

NAME: _____
(PLEASE PRINT)

AKA AND MAIDEN NAMES: _____

DOB: ____/____/____ SSN: ____/____/____

PRESENT ADDRESS: _____

PREVIOUS ADDRESS: _____

I understand that the above information will be used to conduct a criminal records check and I hereby give my permission for criminal records check to be done through the SOUTH CAROLINA LAW ENFORCEMENT DIVISION or any other law enforcement agency.

SIGNATURE: _____ DATE: ____/____/____

The records section charges a fee of \$8.00 each criminal history record request. Payment shall be made by PCBDSN to SLED and a personal self addressed envelope is to be enclosed with the request.

