



8418 East Shea Blvd, Suite 100, Scottsdale, AZ 85260

Phone: (602) 525-0811 Fax (480) 323-2812

www.campsoaringeagle.org

## SUMMER STAFF APPLICATION

**All Applicants must be 18 years of age.**

Applications are received and volunteers are placed without regard to race, creed, color, religion, sex, age, national origin, marital status, physical or mental handicap, veteran status and citizenship status. The receipt of this application does not mean that volunteer openings exist nor does it obligate us in any way. We appreciate your interest in our organization.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: \_\_\_\_M \_\_\_\_ F T-Shirt Size \_\_\_\_\_  
Last First M.I.

Present Address: \_\_\_\_\_ Permanent Address (if different) \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

How did you hear about Camp? Are you affiliated with a partnering group or hospital? \_\_\_\_\_

### CAMPER WEEKEND VOLUNTEERS (3 DAYS):

- |                                |                                 |
|--------------------------------|---------------------------------|
| ____ Group Leader              | ____ Medical Volunteer          |
| ____ Program Leader            | ____ Special Activity Volunteer |
| ____ Dining Hall Volunteer     | ____ Lifeguard                  |
| ____ Hospital Outreach Program |                                 |

### **Pharmacist/PT/Social Worker/RT/Paramedic/EMT/RN/PA**

Please list your professional licensure and or certification information below:

License/Certification Type: \_\_\_\_\_

License/Certification Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Current Place of Employment: \_\_\_\_\_

☐ I certify that during the time I am a volunteer for Camp Soaring Eagle I am fully covered by medical mal-practice insurance. Please specify the carrier and policy holder: \_\_\_\_\_

Please list sessions you are interested in attending: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Please mark any certifications (please attach copies): \_\_\_\_ First Aid \_\_\_\_ C.P.R. \_\_\_\_ Lifeguard \_\_\_\_ Other: \_\_\_\_\_

Please list any languages you speak fluently: \_\_\_\_\_

**Why do you want to work with children who have life-threatening illnesses?** \_\_\_\_\_

**What experiences have helped you prepare for this role?** \_\_\_\_\_

**What do you foresee being your greatest challenge with the lifestyle of camp? How will you manage this challenge?** \_\_\_\_\_

**What experience do you hope to get out of camp?** \_\_\_\_\_

**Please list any special skills, hobbies, or talents you can contribute to the campers' experience:** \_\_\_\_\_

**EDUCATION:**

Name, City &amp; State \_\_\_\_\_

Dates Attended \_\_\_\_\_

Diploma or Degree/Area of Concentration \_\_\_\_\_

High School \_\_\_\_\_

College \_\_\_\_\_

Grad/Other \_\_\_\_\_

**EMPLOYMENT HISTORY:**

Last (or Current) Employer \_\_\_\_\_

Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Employer's Phone # ( ) \_\_\_\_\_

Your Title \_\_\_\_\_

Employment Dates \_\_\_\_\_

Employer's email \_\_\_\_\_

Additional Employer \_\_\_\_\_

Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Employer's Phone # ( ) \_\_\_\_\_

Your Title \_\_\_\_\_

Employment Dates \_\_\_\_\_

Employer's email \_\_\_\_\_

**Camp Experience or Experience working with children:**

Employer \_\_\_\_\_

Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Employer's Phone # ( ) \_\_\_\_\_

Your Title \_\_\_\_\_

Employment Dates \_\_\_\_\_

Employer's email \_\_\_\_\_

**REFERENCES:** (non-family members. NOTE; Different from employers)

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

**Please answer YES or NO to the following questions:**

YES NO

\_\_\_ \_\_\_ Has your name ever appeared on a sex offenders registry?

\_\_\_ \_\_\_ Have you ever been convicted of any crime except a minor traffic offense?

\_\_\_ \_\_\_ Has your driver's license ever been revoked or suspended?

\_\_\_ \_\_\_ Have you ever been fired for cause or suspended/expelled from school?

If you answered yes to any of the above questions, please explain: \_\_\_\_\_

*Please answer honestly. We run a nation-wide criminal background check on all applicants.***Applicant's Certification and Agreement: Please read carefully and sign**

The facts set forth in my application are true and complete. I understand that if accepted, false statements on my application shall be considered sufficient cause for dismissal. I authorize the use of any information on this application and attached supplements to verify my statements, and I authorize the Camp to contact the past employers, schools, and all references listed above.

\_\_\_\_\_  
Signature of Applicant\_\_\_\_\_  
Date\_\_\_\_\_  
Signature of Parent (if applicant under 18)\_\_\_\_\_  
Date



# Volunteer Medical History Form

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

## Emergency Contact Person:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Last Tetanus booster: (date required) \_\_\_\_\_

Significant Medical History (surgery, serious injuries, hospitalizations): \_\_\_\_\_

Allergies (medication, foods, and contact items like insect bites): \_\_\_\_\_

Physical restrictions or limitations to activity: \_\_\_\_\_

Prescription medications or over the counter medications: (Housed counselors will have meds stored in the medical center.) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_

## MEDICAL RELEASE

In case of accident or illness, medical services may be provided by camp medical/nursing staff. In the event of an emergency and you are unable to give consent for care, the medical center staff is authorized to carry out any procedures deemed necessary. Staff members and volunteers assume financial responsibility for all medical expenses incurred while at camp. Medical insurance information is requested in the event a referral of an injured or ill staff/volunteer becomes necessary.

I have read, understand and agree by the above. I attest that I am physically fit for camp and there are no medical restrictions that would prevent me from performing the essential functions of my job. I understand that Camp Soaring Eagle assumes no responsibility for any pre-existing injury or illness.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



## TUBERCULOSIS (TB) RISK FACTOR SCREENING

Universal tuberculin testing is not recommended in the U.S. and other low-incidence countries due to the high rate of false positive results. Tuberculin testing is, however, indicated for children/individuals with risk factors for TB. **Please answer the following questions:**

- |             |    |   |
|-------------|----|---|
| YES         | NO | 1. Are you an immigrant from a country with a high incidence of TB? (Countries not listed in table below).  |
| YES<br>past | NO | 2. Have you traveled to a high-incidence country (not listed in table below) within the year?   |
| YES         | NO | 3. Have you had household contact with an individual who immigrated from a country with a high incidence of TB or an individual who has TB?   |
| YES         | NO | 4. Have you had exposure to individual in the past year who are HIV - infected, homeless, institutionalized, users of illicit drugs, or incarcerated?                               |
| YES         | NO | 5. Do you have HIV infection, diabetes mellitus, chronic renal failure, malnutrition, reticuloendothelial diseases, other immunodeficiency, or receiving immunosuppressive therapy? |
| YES         | NO | 6. Do you work in any type of healthcare facility where you share air space with patients (ex: nurses, therapists, housekeeping, etc...)?   |
| YES         | NO | 7. Have you been hired as a paid staff member for Camp Soaring Eagle (including paid seasonal staff)?   |

If you answered **YES** to any of the questions above, please submit documentation of a **TB** skin test (Mantoux) with your medical form. If the TB skin test is *positive*, you will need to submit evidence of a chest x-ray report.

If you answered NO to all the above questions, please sign below:

I have none of the identified risk factors: \_\_\_\_\_  
Signature Print Name

## APPLICANT RELEASE AND AUTHORIZATION FORM

I hereby authorize \_\_\_\_\_ authorized representatives of the company bearing this release to obtain and release any information pertaining to my background, including any of the services noted below, for employment or volunteer purposes. I hereby fully release and discharge my prospective employer or other source providing information from all claims and damages arising out of or relating to any investigation of my background for said purposes.

APPLICANT SIGNATURE:	
APPLICANT NAME (PRINTED):	
DATE:	
SEX:	

PLEASE PROVIDE SEVEN (7) YEARS OF RESIDENTIAL HISTORY.  
ADDITIONAL YEARS SEARCHED AT CLIENT'S REQUEST.

APPLICANT INFORMATION		
First Name	Middle Name	Last Name

(PLEASE PRINT CLEARLY)

ALIAS INFORMATION		
First Name	Middle Name	Last Name

(PLEASE PRINT CLEARLY)

OTHER INFORMATION	
Date of Birth:	
Social Security Number:	
Drivers License Number:	
State Drivers License Is Issued:	

(PLEASE PRINT CLEARLY)

CURRENT ADDRESS			
Street			
City	State	Zip Code	County
Date From:		Date To:	
(PLEASE PRINT CLEARLY)			

PREVIOUS ADDRESS (1)			
Street			
City	State	Zip Code	County
Date From:		Date To:	
(PLEASE PRINT CLEARLY)			

PREVIOUS ADDRESS (2)			
Street			
City	State	Zip Code	County
Date From:		Date To:	
(PLEASE PRINT CLEARLY)			

**IMPORTANT: FOR CLIENT USE ONLY**

**Mark an "X" to select any of the following:**

**ALIAS/AKA**

Would you like NBI to also check Alias/Other name given?

Yes\_\_\_\_ No\_\_\_\_

(Be advised there is an additional charge for each alias name requested)

**CRIMINAL HISTORY RECORD SEARCH**

**Please specify Counties to be searched:**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

**STATEWIDE SEARCHES**

	Alabama
	Delaware
	Illinois
	Maryland
	Montana
	North Carolina
	Rhode Island
	Utah

	Arkansas
	Florida
	Indiana
	Michigan
	Nebraska
	North Dakota
	South Carolina
	Washington

	Colorado
	Georgia
	Kentucky
	Minnesota
	New Jersey
	Oregon
	South Dakota
	Wisconsin

	Connecticut
	Iowa
	Maine
	Missouri
	New York
	Pennsylvania
	Texas

**OTHER SEARCH TYPES**

	Credit Profile		Global Risk Assessment
	Social Security Trace		National Criminal Record Search (US/SOR Combo)
	Civil Judgment - Upper Court		National Public Sex Offender Registry
	Civil Judgment - Lower Court		State Sexual Offender Registry (specify State)
	Federal Civil		Driver Qualification Report
	Federal Criminal Record Search		Worker's Compensation
	Federal Tax Lien Search		HHS/OIG
	State Tax Lien Search		Active Military Search
	Bankruptcy Search		International Investigation (Please specify country)

**CREDENTIALS AND VERIFICATIONS**

	Education		Professional License
	Employment		Personal Reference
	Residential		Professional Reference

Please specify number of items and attach a detailed sheet

Please Return to: **Camp Soaring Eagle Attn: Tyler Torba** fax to (480) 323-2812.