CAMP HEALING HEART
VOLUNTEER APPLICATION
Friday, October 20, 2017
Volunteers report for training

Saturday, October 21, 2017
Children arrive at 8 a.m.
Closing ceremonies take place from 7-8 p.m.
University of Illinois 4-H Memorial Camp
Near Monticello, Illinois

Mail Completed Applications to:
Carle Hospice
206A West Anthony Drive
Champaign, Il 61820

A SPECIAL DAY CAMP
sponsored by Carle Hospice
for grieving children ages 5 to 17
Dear Volunteer,

Thank you for your interest in becoming a Camp Healing Heart volunteer. Camp Healing Heart will be held at the University of Illinois 4-H Memorial Camp near Monticello, Illinois. To be considered as a camp volunteer, please return the application booklet by October 2, 2017.

Volunteers will be chosen for the positions available based on each volunteer’s interest, abilities, and experience. Some of the volunteer positions require training. Those who volunteer as buddies and facilitators will share in an overnight camp experience with a required training session on Friday night. This will allow buddies and facilitators to get to know each other, familiarize yourself with the camp, and learn about the children you will be serving. There are also volunteer positions which do not require training. You will be oriented to your service Saturday at camp, but please feel free to join us for dinner and team-building festivities on Friday.

After we receive your completed application and forms, and the background check has been completed, a representative from Carle Hospice will contact you regarding available volunteer opportunities. We will do our best to match volunteers with their position of choice, however the number of buddy and facilitator positions are dependent on the number of campers. We usually do not know the final number of campers until a few days prior to camp.

Thank you again for your interest and support in helping Camp Healing Heart make a difference in the lives of grieving children. Please call (217) 383-3488 or (800) 239-3620 if you have any questions or need additional information.

Please mail the completed application in enclosed Self Addressed Stamped envelope.

Sincerely,

Letisha Owens

Camp Healing Heart Staff
Carle Hospice
CAMP HEALING HEART
VOLUNTEER APPLICATION

Personal Information. Please complete each section. Please print.
Name ____________________________________________________________
Address __________________________________________________________
Home Phone __________________ Work Phone __________________ Cell Phone __________________
Date of Birth ___________ Gender: ☐ Male ☐ Female Email Address________________
Occupation _____________________________ Employer _____________________________

Professional Licenses and/or Certifications
<table>
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<th>Type</th>
<th>State</th>
<th>Date</th>
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<th>Expiration Date</th>
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Relevant Training or Workshops
____________________________________________________________________
____________________________________________________________________

General Information
What experience have you had working with children? ____________________________
____________________________________________________________________
____________________________________________________________________

Have you volunteered at Camp Healing Heart before? ☐ Yes ☐ No
If yes, when? ____________________________
____________________________________________________________________
Have you done any volunteer work? If yes, please give brief description. ____________________________
____________________________________________________________________
____________________________________________________________________

My t-shirt size (adult sizes listed): ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large

What is your availability for camp? ☐ Friday only ☐ Friday & Saturday ☐ Saturday only

Are you willing to spend the night? ☐ Yes ☐ No

Will you need to ride the shuttle bus to camp? ☐ Yes ☐ No

Please rank the top three volunteer position(s) you are interested in. If your choice includes “buddy interaction” or “group facilitator”, also mark if you prefer to work with a selected age range.

_____ Buddy 1-1 interaction ☐ young campers ☐ pre-teen/teen campers ☐ either
_____ Group Facilitator ☐ young campers ☐ pre-teen/teen campers ☐ either
_____ Nurse  ☐ Registration & Check-Out  ☐ Photographer
_____ Music Leader  ☐ Recreational Activities  ☐ Arts & Crafts
_____ Runners  ☐ Pet Therapy
MEDIA AUTHORIZATION (PART I)
[This Media Authorization must be accompanied by a Media Waiver form]

Patient/Employee Name: ___________________________________________________ BD: ___/___/____

Phone: ___________________________ E-mail Address: ___________________________

Street Address: _______________________________________________________________________________________

City, State, Zip: _______________________________________________________________________________________

I authorize Carle to release information about me as described below.

1. Carle may use and disclose the information described below to the general public, through media, Carle publications or in other public venues including those listed in the Media Waiver form.

2. I understand that the purpose of the disclosure(s) is for Carle’s own marketing activities and/or general public information, awareness, or education.

3. Specific Records and/or Information to be disclosed verbally, in writing or electronically, as the case may be:

   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

4. Revocation, Re-disclosure, & Expiration. I understand that I may revoke this authorization at any time by submitting a written request to the Marketing & Communications department unless Carle has already acted upon my authorization. I understand that my revocation only applies to uses and disclosures of my personal information by Carle. I further understand that any information already disclosed pursuant to this authorization is no longer protected by the laws and regulations applicable to Carle, and may, therefore, be subject to re-disclosure. Unless specified otherwise by me, this Media Authorization will have no expiration date.

   (Optional expiration date/event. _________________________________________________________________)

5. I understand that my authorization to disclose the above information is voluntary, and Carle will not condition the provision of treatment or payment on this authorization.

Patient/Employee Signature (or Parent/Guardian/Authorized Signature where applicable) __________________________ Date __________________________

Authority to Sign, if not the Patient/Employee

NOTE: This authorization may not be used for the marketing of outside parties’ products.
MEDIA WAIVER (PART II)
[Must be accompanied by a Media Authorization form]

I, (print patient/employee name) _______________________________   BD: ____/____/_____, have given my permission for Carle to make or produce photographs, written accounts and transcriptions, video recordings and transmissions, and/or audio recordings and transmissions of me/the patient, and reproductions of the same (collectively, “marketing pieces”), and have authorized those entities to use and disclose such marketing pieces and the information contained therein for the purposes described in my signed Media Authorization. I hereby waive any right to inspect or approve the marketing pieces, including but not limited to any photograph, video, advertising copy or printed matter that may be used. I agree that all reproductions including, but not limited to, plates, negatives, electronic images and other exposed film are and shall remain the property of Carle and may be edited and used in printed materials, sound films, audio and video tapes, radio and television broadcasts, internet and World Wide Web applications or otherwise, in accordance with the terms of my signed Media Authorization. On my behalf, and on the behalf of my child as applicable, I hereby release Carle, their licensees, agents, successors and assigns from any and all claims for damages for libel, slander, invasion of privacy or any other claim based upon the above described material.

I have read the entire document, understand the contents, have had the opportunity to ask questions and willingly agree to the above conditions. This waiver will remain in effect indefinitely.

____________________________________________________________________
Patient/Employee Signature (or Parent/Guardian/Authorized Signature where applicable)   Date

____________________________________________________________________
Authority to Sign, if not the Patient/Employee
CAMP HEALING HEART
VOLUNTEER STATEMENT OF CONFIDENTIALITY

I understand that information regarding Camp Healing Heart campers, their families, staff and any persons receiving support or services in any capacity is privileged information for use by and with authorized person(s) only.

I will disclose such information only in the discharge of my assigned duties and responsibilities with Camp Healing Heart or person(s) 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 person(s). I also understand that the casual sharing of camper/camper families/staff information in public places or settings is inappropriate.

I have read and understood the preceding Statement on Confidentiality and agree to abide by it.

Print Name: ______________________________________________________________________________________________

Signature: ___________________________________________________________________ Date: ____________________

CAMP HEALING HEART
VOLUNTEER INDEMNIFICATION AGREEMENT

1. I, for myself, release and discharge Carle Hospice, its Agents, Employees and Volunteers, from all claims, demands, actions and judgments, which I ever had or now has or may have against Carle Hospice for all personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by myself or property during my attendance of Camp Healing Heart, whether the injury is caused by negligence or any other fault.

2. I agree to indemnify and hold harmless Carle Hospice for any and all claims, demand, actions and judgments whatsoever of every name and nature, both in law and equity, which I ever had or now has or may have against Carle Hospice for all personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by myself or property during my attendance at Camp Healing Heart, including but not limited to, injury caused by or arising from Carle Hospice's own negligence.

I the undersigned have read this release and understand all of its terms.

Signature: __________________________________________________________ Date: __________________
In connection with my application for employment, and/or employment with (Carle Foundation Hospital) (“Company”), I, __________________________ (applicant’s or employee’s name), understand and am hereby notified and authorize Company to procure a consumer report from a consumer reporting agency in accordance with the Fair Credit Reporting Act, 15 U.S.C. 1681 et seq. (the “FCRA”), or any “person” as defined under the California Consumer Credit Reporting Agencies Act (if a CA applicant) for evaluation of me for employment (i.e. employment, promotion, reassignment, or retention as an employee). I understand that these consumer reports may contain information from public records, including written, oral, or other communications bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, which may or may not be used as a factor for employment purposes. I further understand that such inquiries may include, but are not limited to, criminal history, motor vehicle records, employment history and verification, income verification, DOT verifications, military background, civil listings, education background, and professional background, from any individual, corporation, partnership, law enforcement agency, institution, school, organization, credit bureau, state board, licensing agency, and other entities, including present and past employers.

In connection with my application for employment and/or employment with Company, I further understand and am hereby notified that Company may procure an investigative consumer report concerning me from a consumer reporting agency or any “person” as defined by the California Consumer Credit Reporting Agencies Act (if a CA applicant). I understand that an investigative consumer report may contain information from public records, including but not limited to, written, oral or other communications bearing on my credit worthiness, credit standing, character, general reputation, personal characteristics, or mode of living, which may be obtained through personal interviews with neighbors, friends or associates of me and may or may not be used as a factor for employment purposes. I further understand that such inquiries may include, but are not limited to, investigations regarding worker’s compensation, harassment, violence, theft, or fraud.

I have received and reviewed a copy of the Summary of Rights under the FCRA and the California Investigative Consumer Reporting Agencies Act (If a California applicant). I understand that I have the right to request, in writing, information regarding the nature and scope of any investigative report prepared on me.

I authorize without reservation any party or agency contacted by this employer to furnish the above-referenced information. I further authorize ongoing procurement of the above-referenced reports at any time, either during the time my application for employment is being considered or throughout the duration of my employment in the event that I am hired or am a current Company employee.

My Social Security number is __________________________. My Date of Birth (“DOB”) is __ / __ / ____ ** Please see below. ** If ME, MI, MN, OH, PA, RI, or WV applicant DO NOT provide DOB. Instead call 877-292-3331 within 2 hours of submitting your application.

My Previous Name (if any) is __________________________.

My Drivers License number is __________________________ and was issued by the state of ________.

If you have had another Drivers License in the last three years please put that number here: __________________________.

My High School, named __________________________, is located in (City) __________, (State)_________.

Current Address:

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<tr>
<th>No. Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
<th>Years</th>
</tr>
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</table>

Previous Addresses within the last seven (7) years: (Attach additional pages if necessary)

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Oklahoma, Minnesota and California applicants only:

You have the right to receive a copy of your Consumer Credit Report free of charge should one be requested for employment purposes. I, __________________________ (applicant’s or employee’s name), understand and authorize procurement of the above-referenced information. I further authorize ongoing procurement of the above-referenced reports at any time, either during the time my application for employment is being considered or throughout the duration of my employment in the event that I am hired or am a current Company employee.

Applicant Signature: __________________________________ Date: ____________________

I acknowledge that I have voluntarily provided the above the above information for employment purposes, and I have carefully read and I understand this authorization.

**The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.

Client Account Number: 927917 – Carle Foundation Hospital

Private Eyes, Inc. 190 North Wiget Lane, Suite 220, Walnut Creek, CA 94598 at (925)927-3333 or (877)292-3331 Fax(877)292-3330
I, (print name)_____________________________ hereby confirm that I understand and agree with each and all of the following statements regarding participation in the Challenge Course and High Adventure Activities at the University of Illinois 4-H Memorial Camp. I am aware and understand that participation in a challenge course program is physically challenging, potentially dangerous and involves risk of injury, serious injury, and/or death. Participation is strictly optional.

1. I understand that the program or any part of it may have to be cancelled or re-scheduled on short notice due to unforeseen circumstances, including but not limited to bad weather. In such cases, the program may be re-scheduled.

2. I shall hold harmless the University of Illinois, the University of Illinois 4-H Camp, it's employees, it's instructors, activity and/or program leaders, and all others involved in planning, organizing, and conducting this activity/program from any and all claims, including but not limited to claims of injury or loss of life and property that may occur arising out of my participation in this program. I shall exercise caution and solely accept full responsibility for any injuries and/or loss that may occur to me, or my property; as well as injury or harm to others or their property, which are my fault.

3. I acknowledge that, despite knowing the potential for harm, I am still a willing participant in the activity/program.

4. I further acknowledge/confirm that the University of Illinois is not responsible for any lost time or lost wages I am suffer as a result of my participation in this activity/program.

NAME (please print):______________________________________________________
Mailing Address:__________________________________________________________
Program Date:____________________________________________________________

Health History – Voluntary Disclosure:
The purpose of collecting this information is to ascertain your ability to participate safely in this activity.

1. Would you describe your current physical fitness and activity level as either:
   - [ ] LOW
   - [ ] MEDIUM
   - [ ] HIGH

2. Is there a medical condition you should disclose prior to engaging in this activity which may affect your participation, including but not limited to a heart condition; pre-existing injury to ankle, knee, or back; any medications that could impact your health or safety; and/or any allergies you may have (food, insects, bees, medications, etc.)
   - [ ] NO
   - [ ] YES Details: ____________________________________________________

In case of Emergency notify:
Contact: (Name)______________________________Relationship:__________ Phone No.____________

Participant Signature:_________________________________________________ Date:_______________

Parent/Guardian Signature:___________________________________________  Date:_______________
(If participant is under 18 years old)
DRIVING DIRECTIONS TO UNIVERSITY OF ILLINOIS
4-H MEMORIAL CAMP AT ALLERTON PARK

• From I-72 Monticello, Illinois, Bridge Street Exit
• At Exit stop sign turn left and travel .4 mile to Old Route 47 (1625N)
• Turn right and travel 1.8 miles to 625E
• Turn left and travel .7 mile to County Farm Road (1550N)
• Turn right and travel .4 mile to Big Timber Road (500E)
• Turn left and travel 1.3 miles to Camp
• Turn right to enter Camp

WATCH FOR CAMP HEALING HEART SIGNS AND 4-H MEMORIAL CAMP SIGNS

University of Illinois
4-H Memorial Camp
Near Monticello, Illinois

Please call Letisha Owens at (217) 383-3488 or (800) 239-3620 if you have any questions or need additional information. You may also email letisha.owens@carle.com.

PACKING LIST
- Pillow
- Towel
- Sleepwear
- Soap and shampoo
- Comb/brush
- Twin sheets or sleeping bag
- Extra pair of shoes
- Extra socks
- Shower shoes or flip flops
- Toothbrush and toothpaste
- Toiletries
- Jacket
- Rain gear
- Deodorant