



Dear Volunteer,

The staff at On With Life is pleased that you are interested in our volunteer program. We strive to offer volunteers the opportunity to assist persons served/patients and their families and friends in an understanding and caring environment.

The following procedure is required:

- 1) Complete Application
- 2) Sign Background Check, Release of Liability and Confidentiality Agreement
- 3) Return all Forms to the Volunteer Coordinator
- 4) Schedule a Tour of the Facility and Watch Orientation Videos
- 5) Sign-in Each Time You Volunteer
- 6) Wear Volunteer ID Tags on Each Visit
- 7) Memorize the Code for the Security System
- 8) Wash Hands Before and After You Volunteer with a Person Served/Patient

On your first visit, please plan to meet with me to discuss your interests and availability as well as those of the facility.

The front desk is the central location where you may sign in, pick up a name tag, and read a variety of information on volunteering.

Thank you again for your interest in the On With Life volunteer program and do not hesitate to contact me if you have further questions.

Sincerely,

Ann Lenaghan

Ann Lenaghan, Volunteer Coordinator
On With Life at Ankeny
Tel: 515-965-1339 ext. 200
alenaghan@onwithlife.org



Brain Injury Rehabilitation Specialists

Volunteer Information
715 SW Ankeny Road
Ankeny, Iowa 50023-9978
(515) 965-1339 ext.200

The following information will help us to find the most satisfying and appropriate volunteer service for you. Your cooperation in completing this application is most appreciated. All applicants are considered without regard for race, color, religion, sexual orientation.

Date: _____
 Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ E-Mail: _____
 Phone: _____ Phone (Cell): _____
 Best way to get in touch with you: _____
 Place of Employment: _____
 Why do you want to volunteer at On With Life? _____

Interests:

Is there a particular type of volunteer work you are interested in? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> One-to-One Companionship | <input type="checkbox"/> Cut/Trim Hair/Licensed Hair Stylist |
| <input type="checkbox"/> Entertainment | <input type="checkbox"/> Computer/Data Entry |
| <input type="checkbox"/> Community Outings | <input type="checkbox"/> Fund Raising Projects |
| <input type="checkbox"/> Assisting with Group Activities | <input type="checkbox"/> Clerical Assistance |
| <input type="checkbox"/> Recreational Activities: Nights and Weekends | <input type="checkbox"/> Answering Phones |
| <input type="checkbox"/> Swimming Assistance | <input type="checkbox"/> Bulk Mail Group |
| <input type="checkbox"/> Music Therapy Assistance | <input type="checkbox"/> Gardening Projects |
| <input type="checkbox"/> Photography/Video | <input type="checkbox"/> Grounds Keeping |
| <input type="checkbox"/> Craft Instructor | <input type="checkbox"/> Cleaning Vehicles |
| <input type="checkbox"/> Special Event Projects | <input type="checkbox"/> Prayer Partners |
| <input type="checkbox"/> Physical Therapy Observation | <input type="checkbox"/> Occupational Therapy Observation |
| <input type="checkbox"/> Pet Therapy – Pet Name _____ | <input type="checkbox"/> Other _____ |

Special skills, interests and hobbies: _____

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

I would like to volunteer _____ Hours _____ Weekly _____ Monthly _____ Upon Request

Will you need verification of volunteer hours? _____ No _____ Yes If yes, why? _____

How did you hear about volunteer opportunities at On With Life?

Radio

School

Newspaper

Work

Another Volunteer

Another Medical Facility

Other. Please List _____

Have you ever volunteered at On With Life before? _____ When? _____

In Case of Emergency, notify: _____
Name Day Phone Number Evening Phone Number

Do you have a record of founded child abuse or dependent adult abuse, or have you ever been convicted of a crime in this state or any other state, not including traffic tickets (a conviction is not necessarily a bar to volunteerism)?

No Yes If yes, please give detailed explanation including dates, locations, and nature of the offense

Other Volunteer Experiences:

Have you ever volunteered at other places? No Yes If yes, Please List Below:

Name City/State Phone Number Supervisors Name Hours/Week

Name City/State Phone Number Supervisors Name Hours/Week

References:

Name Address City/State Phone

Name Address City/State Phone

Name Address City/State Phone

I agree to abide by the policies and procedures of On With Life and will respect the confidentiality of information concerning the persons served which I may learn during the course of my volunteer service. I understand that my volunteer experience can be terminated at any time.

Signature

Date

On With Life at Ankeny

Volunteer Media Release Form

I, the undersigned, do hereby give and grant permission to On With Life to use _____ name, picture(s), volunteer statement, and biographical history in *The Headway* (a quarterly newsletter published by the Corporate Office of On With Life), Public Relations & Volunteer Bulletin Boards within the facility (for recognizing current volunteers and recruiting new volunteers), or in printed materials (including brochures and display photos) for the purpose of marketing On With Life's volunteer program and services to the general public.

Date: _____ **Name** *(Please Print)* _____

Signature of Volunteer: _____

On With Life at Ankeny

Volunteer Release of Liability

I understand that there are inherent physical risks while working with persons served that may include, but are not limited to, injuries associated with lifting or assisting a person served; injuries that may be inflicted by the person served, and injuries sustained while manipulating equipment used by persons served.

Initial _____

The undersigned has agreed to engage in volunteer services for On With Life, Inc and in consideration for the satisfaction of helping my fellow being and the experience I will gain from my activities, hereby releases On With Life, Inc. its employee, officers, directors, attorney, and other volunteers from any and all claims, actions, causes of actions, demands, rights, damages, costs, loss of compensation or services, expenses, and liability of any kind, which may occur during the performance of or on connection to/with any volunteer activities.

Additionally, the undersigned binds this release on the undersigned's guardian, agents, executors, administrators, personal representatives and/or assigns, forever.

Date: _____

Volunteer Name: _____
Print Name Sign Name

Volunteer Address: _____

If the volunteer is a minor (under the age of 18) or is under a guardianship, by signature below, the guardian or parent hereby acknowledges and accepts the terms above, on behalf of the volunteer.

Parent or Guardian

Address

On With Life at Ankeny

Confidentiality Agreement

Statement of Policy: All On With Life staff/students/volunteers/contractors will preserve the confidentiality of persons served's, employee and medical record information. Unauthorized release, inappropriate exchange or mishandling of confidential information is a source of potential liability and is subject to disciplinary action.

Procedure:

- 1) Confidential information includes the person served's medical record, computerized person served/resident/employee information, clinic documents (unless designated for public distribution/posting), and verbal/written information obtain during the discussion of the facility business.
- 2) All information exchange concerning On With Life business, employees, or persons served must take place between authorized persons on a need-to-know basis.
- 3) Supervisors are responsible for determining the extent of information that each employee may access. This includes paper documents, computer stored data and verbally solicited information. On With Life reserves the right to electronically monitor access codes used to gain entry in computer records in order to verify that only authorized access is occurring.
- 4) Confidential information, which identifies individual and is to be electronically transmitted by FAX machine must be safeguarded form discovery by authorized individuals. Information must not be sent by FAX if reliability of receiver is in question.
 - 4:1 A "Confidential Information" cover memo must accompany any FAX containing person served information or other confidential data.
- 5) Due to a person served's "Right To Know", requested person served information may be released to the person served after identity verification.
 - 5:1 Requests for person served information from someone other than the person served, can be honored only after first verifying that the person served has authorized the release of information, the requesting party has the legal right to access the information.

I have read the above and agree to abide by the policy.

Date: _____

Employee/Student/Volunteer/Contractor Signature Printed Name of the Individual and/or Company

Iowa Department of Human Services

REQUEST FOR DEPENDENT ADULT ABUSE REGISTRY INFORMATION

To request information about dependent adult abuse, complete this form and mail it to:

**Central Abuse Registry, Iowa Department of Human Services,
1305 E Walnut, Des Moines, Iowa 50319-0114.**

Note: Information will be released only to people who have access to it under Iowa Code section 2358.6.

Criminal Penalties (2358.12)

1. Any person who willfully requests, or seeks to obtain dependent adult abuse information under false pretenses, or who willfully communicates or seeks to communicate dependent adult abuse information to any agency or person except in accordance with section 235B.6 and 235B.8, or any person connected with any research authorized pursuant to section 2358.6 who willfully falsifies dependent adult abuse information or any records relating thereto, is guilty of a serious misdemeanor. Any person who knowingly, but without criminal pm-poses, communicates or seeks to communicate dependent adult abuse information except in accordance with section 235B.6 and 235B.8 shall be guilty of a simple misdemeanor.
2. Any responsible grounds for belief that a person has violated any provision of this chapter shall be grounds for the immediate withdrawal of any authorized access such person might otherwise have to dependent adult abuse information.

Redissemination of Dependent Adult Abuse Information (2358.8)

1. A recipient of dependent adult abuse information authorized to receive the information shall not disseminate the information, except that dissemination shall be permitted when all of the following conditions apply:
 - a. The dissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities .
 - b. The person to whom such information would be disseminated would have independent access to the same information under section 2358.6.
 - c. A written record is made of the dissemination, including the name of the recipient and the date and purpose of the dissemination.
 - d. The written record is forwarded to the registry within thirty days of the dissemination.

Name of person making request:	Office phone:	
Office address:		
Position and basis for authorization (Code 235B.6):		
Information requested concerning (name-first, middle, last):	Social security number:	Birth date:
Maiden name or alias (if applicable):	Address:	
What information is requested:		
Date	Signature	
To be completed by Registry personnel	Date:	
Request approved by:		
Request denied because:		
Information released:		

AUTHORIZATION FOR RELEASE OF CHILD ABUSE INFORMATION

This form must be used to authorize release of child abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person about whom information is requested.

Send the original to the Central Abuse Registry, Iowa Department of Human Services, 1305 E Walnut Street, Fifth Floor, Des Moines, Iowa 50319~0114.

PART A: <i>To be completed by the person requesting information.</i>			
1.	Requester		
	Address		
	City	State	Zip Code
	Phone Number ()		
2.	The information concerns:		
	Name (first, middle initial, last)		
	Maiden Name or Alias (if applicable)	Birth Date	Social Security Number
	Address		
	City	State	Zip Code
	County		
3.	What is the purpose of your request for child abuse information?		
4.	I have read and understand the legal provisions for handling child abuse information which are printed on the back of this form.		
	Signature		Date
PART B: <i>To be completed by the person authorizing the Department of Human Services to release child abuse information.</i>			
I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse Registry in a child abuse report as having abused a child (Iowa Code 235A.15). To the best of my knowledge, all or part of the information contained in Part A of this form is correct.			
	Signature		Date
PART C	<i>To be completed by the Central Abuse Registry or designee.</i>		
	<input type="radio"/> The person named in item A-2 is listed on the Child Abuse Registry as having abused a child. <input type="radio"/> The person named in item A-2 is not listed on the Child Abuse Registry as having abused a child. <input type="radio"/> This request for information is denied because the form is incomplete.		
	Signature		Date
Comments			

LEGAL PROVISIONS FOR THE HANDLING OF CHILD ABUSE INFORMATION

Redissemination of Child Abuse Information (Iowa Code 235A.17)

A person, agency, or other recipient of child abuse information shall not redisseminate this information. However, redissemination is permitted when all of the following conditions apply:

- The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- The person to whom the information would be redisseminated would have independent access to the same information under Iowa Code Section 23 5A.15.
- A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code 235A.21)

Any person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain child abuse information under false pretense.
- Willfully communicates or seeks to communicate child abuse information to any agency or person except in accordance with Iowa Code Sections 235A.15 and 235A.17.
- Is connected with any research authorized pursuant to Iowa Code Section 235 A.15 and willfully falsifies child abuse information or any records relating to child abuse.

Upon conviction for each offense, the person shall be punished by a fine of up to \$1,000 or imprisonment for not more than two years, or by both fine and imprisonment.

Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child abuse information except in accordance with Iowa Code Sections 235A.15 and 235A.17 shall be fined not more than \$100 or be imprisoned not more than ten days for each such offense.

Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapter 235A shall be grounds for the immediate withdrawal of any authorized access that the person might otherwise have to child abuse information.

IOWA HEALTHCARE FACILITY (135C) RECORD CHECK

Form C

ACCOUNT NUMBER: 7396C

TO: Iowa Division of Criminal Investigation
Bureau of Identification, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 (fax)

FROM: On With Life, Inc
715 SW Ankeny Road
Ankeny, Iowa 50023
515-965-1339
515-964-0567 (fax)

I am requesting an Iowa Criminal History Check on:

<u>REQUEST</u>		
_____	_____	_____
Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
_____	_____	_____
Date of Birth (mandatory)	Sex (mandatory)	Social Security Number (mandatory)

Signature of Requester		

There is a separate Form "C" required for each last name submitted.

(DCI Use only)	
<u>RESULTS</u>	
As of _____, a Name and date of birth checked revealed:	
<input type="checkbox"/> CCH Record Attached	<input type="checkbox"/> No CCH Record
DCI initials _____	

I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation.

_____	_____
Signature	Date