Nemours. Alfred I. duPont Hospital for Children

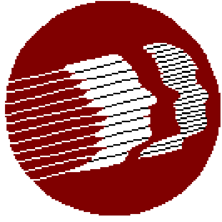
Adult Volunteer Program

Required Forms

Please complete and return the following five forms:

1. Adult Abuse Authorization Form
2. Background Check Authorization Form
3. Child Abuse Authorization Form
4. Volunteer Confidentiality Agreement
5. Authorization to Release Photo/Video/Audio Form

Please do not fax to the State! Needs to be returned to the Volunteer Services Office.



DELAWARE HEALTH & SOCIAL SERVICES
Division of Long Term Care Residents Protection
Adult Abuse Registry
3 Mill Road, Suite 308
Wilmington, DE 19806-2164

AUTHORIZATION TO
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF LONG TERM CARE RESIDENTS PROTECTION
FOR THE RELEASE OF ADULT ABUSE REGISTRY INFORMATION

Employer: **Nemours/Alfred I. duPont Hospital for Children**

Address: **1600 Rockland Road**
Wilmington, DE 19803

I hereby authorize the indicated employer to obtain from the Division of Long Term Care Residents Protection any information concerning me which may be on the Adult Abuse Registry pursuant to 11 Del. C., § 8564.

APPLICANT **(Black or Blue Ink Only)**

________________________________ __________________________
PRINT NAME SOCIAL SECURITY NUMBER

________________________________ ____________________
SIGNATURE DATE

8/8/16

Nemours. Alfred I. duPont Hospital for Children

BACKGROUND CHECKS

I understand that any offer of participation with Nemours is contingent upon satisfactory references and a background check for criminal record. Information received from the background check will remain confidential.
NOTE: We require home addresses going back seven (7) years.

I authorize Nemours and/or its designated agency (Certiphi Screening) to contact my previous employers and complete a background check for a criminal record.

SIGNATURE: ____

DATE: ____

COMPLETE THE INFORMATION BELOW
(Please print large and clear)

NAME:

____
(Last) **(First)** **(M.I.)**

MAIDEN and/or OTHER NAME(S): ______________________________

SOCIAL SECURITY NUMBER: __________-________-__________

DATE OF BIRTH: ______________________

Current Address: ____
(Street) **(City)** **(State)** **(Zip)**

County: ____________________ **Number of years:** __________

Previous Address: ____
(Street) **(City)** **(State)** **(Zip)**

County: ____________________ **Number of years:** __________

Previous Address: ____

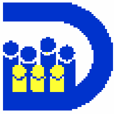
County: ____________________ **Number of years:** __________

Previous Address: ____

County: ____________________ **Number of years:** __________

Previous Address: ____

County: ____________________ **Number of years:** __________



DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Email, fax, or mail request to:

Criminal History Unit
Concord Plaza, Hagley Building
3411 Silverside Road
Wilmington, DE 19810
Phone: 302-892-5800 Fax: 302-633-5191
Email: DSCYF_CHU@delaware.gov

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed**
- **Do not use a cover sheet**
- **Do not send duplicate requests**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed**

PART I. APPLICANT INFORMATION (*PLEASE PRINT CLEARLY*)

Name:__ ____
Last First Middle

Other Name(s) used: ________________________________ DE Driver's License #______________

Social Security # ___ ___ ___ ___ ___ ___ ___ ___ ___ Date of Birth: ____________ Gender:____ Race:_________
mm-dd-yyyy

Address:____
(Street) (City) (State) (Zip)

Are you on the Delaware child protection registry for any substantiated cases of child abuse/neglect? [ ] Yes [ ] No

If yes, explain: ____

____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Delaware child protection registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature:____ Date:________________________

Parent / Guardian Signature (If applicant is under the age of 18) ____

PART II. AGENCY INFORMATION - (*MUST BE COMPLETED IN ORDER TO PROCESS*)

Agency Identification Number (if applicable): _8__

Contact ID: _2441_

Requesting Agency Name: _A. I. DuPont Hospital for Children – Volunteer Services

Address: _1600 Rockland Road, Wilmington, DE 19803

Phone: (302)651-6096 Fax: (302)651-4083 Contact Person: _Judy Lieberman

Contact Email: _volunteers@nemours.org

DSCYF USE ONLY:

The individual listed above (__ is listed) (___ is NOT listed) on the Delaware Child Protection Registry.

Date: ____________ DSCYF Criminal History Unit ____

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Nemours. Alfred I. duPont Hospital for Children

VOLUNTEER CONFIDENTIALITY AGREEMENT

I understand that I may be exposed to information regarding Nemours' Associates, visitors, patients, business practices, or other information of Nemours (collectively, the "Confidential Information") when I am present at a Nemours site or when performing volunteer services at any Nemours or outside location on behalf of Nemours. I agree to keep all Confidential Information strictly confidential and agree not to disclose to anyone or use for any purpose any Confidential Information without specific authorization in advance in writing by the Nemours site Administrator. The term Confidential Information does not include information regarding Nemours which is already in the public domain through the marketing efforts of Nemours or as reported in the media.

I also understand that protected health information (PHI) regarding patients of Nemours is protected from unauthorized disclosure by state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). I have been provided training regarding protected health information, HIPAA and other confidentiality laws and agree to keep strictly confidential any information regarding the identity, diagnosis, treatment, and financial, family or social situation of any Nemours patient.

I understand that Nemours has many policies and procedures regarding its business and patient operations which may be relevant to my service as a Nemours Volunteer. I have received information and training on these policies and procedures and agree to comply with those policies and procedures that are applicable to the services I provide on behalf of Nemours as a Nemours Volunteer. I also understand that if I need additional information or have questions regarding any policy or procedure, I should ask the Director of Volunteer Services or the site Administrator at the Nemours location where I provide services, as appropriate.

I understand that my failure to comply with Nemours policies and procedures, or to adhere to the confidentiality requirements of this Agreement, may result in my dismissal as a Nemours Volunteer and could subject me to legal action. I also understand that I am still obligated to comply with my confidentiality obligations under this Agreement even after I am no longer serving as a Nemours Volunteer.

Finally, I understand that my signing this agreement does not transform my status at Nemours from that of a volunteer into an employee or provide me with any other contractual rights. I agree to the obligations and responsibilities stated above.

______________________________ Print Name of Volunteer

______________________________ Signature of Volunteer

______________________________ Today's Date

Authorization to Release Photo/Video/Audio for Publication

Adult, Non-Associate

1. I, (print name) ____, authorize Nemours to USE AND/OR DISCLOSE the above-named person's information and story with media outlets, social media channels and networks, advertising, websites, public marketing, promotional materials, training and/or presentation and other similar venues.

2. The following people and/or media organizations will have access:
   ____
   ____

3. This authorization will expire on:
   ❑ A specific date (if checked, enter the date) _________________, OR ❑ the following event/service: ______________________
   ❑ Agreement to use expires 10 years from date this form is signed.

   I understand that:

   - I can change my mind and revoke this authorization, in writing, at any time, by sending a written revocation to the Nemours Privacy Officer at 10140 Centurion Parkway North, Jacksonville, Florida 32256. **1-800-472-6610**

   - Information used or disclosed may be redistributed by the recipient and may no longer be protected by Federal or state confidentiality law.

     - It is common that disclosures for broadcast or publication will include posting the materials onto Web, social media, or similar sites. Once this occurs your information will be publicly available and freely distributed.

   - I will receive a copy of this Authorization if requested.

______________________	______________________	______________________
Signature	Printed Name	Date

______________________	______________________	______________________
Home Phone #	Cell Phone #	Email Address

.

To be completed by Nemours Associate:

Purpose of photo/video: ____________________________________

Situation in photo/video: ___________________________________

Adult's gender *(circle one)*: Male/Female

Adult's description in photo/video (hair color, clothing): _________
____

Name of staff person: ______________________________________

Department:____

Nemours location:____

Date photo/video taken:_____________________________________