



## **College 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
6. Immunization Form for College Volunteers

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

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 \_\_\_\_\_

## 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: _____	Name of staff person: _____
Situation in photo/video: _____	Department: _____
Adult's gender (circle one): Male/Female	Nemours location: _____
Adult's description in photo/video (hair color, clothing): _____	Date photo/video taken: _____
_____	



**Immunization Record**  
**College Volunteers**

Please provide a copy of your immunization history by either method below:

- Have your physician complete *and* sign this form *OR*
- Attach a copy of your medical record to this form in lieu of Physician's Signature

Name: \_\_\_\_\_

Department: Volunteer Services

Date of Birth: \_\_\_\_\_

**Dates of Mandatory Immunizations**

(If you do not have proof of these immunizations, you can have blood titers drawn at your physician's office or a Quest location)

MMR (measles, mumps, rubella): 1) \_\_\_\_\_ 2) \_\_\_\_\_

Varicella (Chicken Pox) Vaccine: 1) \_\_\_\_\_ 2) \_\_\_\_\_ *OR*

Documented Date of Chicken Pox or Shingles \_\_\_\_\_

**Tuberculosis (PPD) Testing:**

(Proof of two PPDs given within the last 6 months are required)

PPD 1 (Mantoux): Date Applied: \_\_\_\_\_ Results \_\_\_\_\_ mm

PPD 2 (Mantoux): Date Applied: \_\_\_\_\_ Results \_\_\_\_\_ mm

Quantiferon Gold test result (if history of positive PPD skin test) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

This form and any attachments may be emailed to [volunteers@nemours.org](mailto:volunteers@nemours.org) or hand-delivered to the Volunteer Services office.