



Cleared: _____

Date: _____

Volunteer Application 2021-2022

Please return completed forms to:

rmurphy@FAR-therapy.org

Legal Name

Date of Birth: ____/____/____

☐ Male ☐ Female ☐ Other Ethnicity (optional): _____

Street Address

City

Zip Code

Primary Phone

Secondary Phone

Driver's License Number

E-Mail Address

Place of Employment or School - Title

Emergency Contact /Relationship

Phone number

Will you be receiving credit for volunteering? ☐ Yes ☐ No

How did you learn about FAR? _____

Do you have experience working with persons with special needs? ☐ Yes ☐ No

If yes, list experiences _____

Where would you like to volunteer?

____ Music Therapy ____ Rec Therapy ____ Go FAR Parties ____ Bowling ____ Social Connections

____ Other: _____

Revised 8/31/2021

Staff Initials: _____



PHOTO RELEASE

I, _____ hereby grant FAR Therapeutic Arts and Recreation permission to publish my/my child's photograph(s), video and audio in agency publications in print, electronic communications or on the agency website located at www.far-therapy.org.

FAR is a 501(c)(3) nonprofit agency.

By signing below, I acknowledge my understanding of the above and grant my permission for the use of the photograph(s), video or audio.

(Please print name)

SIGNATURE

DATE

PARENT'S SIGNATURE, IF UNDER 18 YEARS OF AGE

DATE

BACKGROUND CHECK

I acknowledge the fact that a criminal records search will be performed by the FAR office.

SIGNATURE

DATE

PARENT'S SIGNATURE, IF UNDER 18 YEARS OF AGE

DATE



Confidentiality Policy

FAR Therapeutic Arts and Recreation ("FAR") maintains records of all clients that are confidential in nature and for FAR use only. All volunteers are required to maintain such information in strict confidence.

Confidentiality is the preservation of privileged, personal information and, while private information will be disclosed to you as a necessary part of the services you provide to our clients, all information concerning clients and former clients of FAR is to be treated as confidential. "Confidential" means that you are free to talk about FAR and about your position, but you are not permitted to disclose clients' names, diagnosis, or talk about them in ways that will make their identity known. FAR expects you to respect the privacy of the clients we serve and to maintain their personal information as confidential at all times both during and after your service to FAR. This is a basic component of client care and business ethics. Disclosure of any confidential information is a direct violation of this policy. Should an occasion arise in which you are unsure of your obligations under this policy, it is your responsibility to consult with your FAR supervisor.

By signing this Confidentiality Policy, I agree to maintain professional confidentiality for all persons served by FAR Therapeutic Arts and Recreation as outlined above. I also agree to inform my FAR supervisor immediately if I believe any violation (unintentional or otherwise) of the policy has occurred. I understand that violation of this policy will lead to disciplinary action, up to and including termination of my service with FAR.

Signature _____

Date _____

Name _____

Staff Witness _____

Date _____

Name _____



Volunteer Medical Policy and Consent Form

FAR staff is dedicated to creating a fun and safe therapeutic environment for our clients, families, and volunteers. To ensure that everyone has a safe experience, please review the following medical policy.

1. All FAR staff is certified in CPR and basic First Aid and will intervene on behalf of you/your child in the event basic care is required. In the event of any incident, your emergency contact/you will receive a phone call from a FAR staff member and a written Incident Report.
2. In the event of a medical emergency, FAR will call 911 on behalf of you/your child; **FAR, however, holds no financial responsibility for any medical services requested or rendered.** A staff member will provide basic care as needed until professional help arrives. Your emergency contact/you will immediately be contacted by a FAR staff member and provided with a written Incident Report.
3. **FAR staff is not authorized to dispense OTC or prescription medication to minor children or anyone under guardianship.** Should you/your child require medication of any kind while at FAR, it must be administered by a **parent, legal guardian, or professional medical personnel.**

I consent to the above FAR policy for me/my child regarding any such medical circumstances, including any accident or illness, which may necessitate medical treatment and authorize any such treatment or medical response that FAR's staff, in its sole discretion, may deem necessary. I further acknowledge that I understand the above policy and agree to abide by its terms.

_____ Name of Volunteer (over 18)	_____ Signature	_____ Date
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_____ Name of Volunteer (under 18)	_____ Signature	_____ Date
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_____ Parent/Guardian (if under 18)	_____ Signature	_____ Date
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_____ Emergency Contact (Please print)	_____ Phone Number	_____ Relationship
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Revised 8/31/2021
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COVID POLICY

As of September 3rd, 2021, all staff and volunteers are required to be fully vaccinated.

COVID-19 Vaccination Status: ☐ Yes ☐ No

****Please provide a copy of your vaccine card****

Per **CDC** Interim Public Health Recommendations for Fully Vaccinated People, **FAR will require:**

- Fully vaccinated people who have come into close contact with someone with suspected or confirmed COVID-19 to be tested 3-5 days after exposure, and to wear a mask in public indoor settings for 14 days or until they receive a negative test result.
- If you have been directly exposed to, diagnosed with, or tested positive for COVID-19 you are required to immediately inform the **FAR President, Pamela Ayres** at **248-444-0300** so that appropriate precautions can be taken.

Self-Monitoring

Self-monitoring is an essential component to keeping the FAR community healthy.

All volunteers are asked to prescreen themselves before entering the building, and are asked **NOT** to enter the building, if they are not feeling well.

Prescreening is defined as asking one's self the following 3 questions:

1. Do you have a measured temperature above 100.4°F degrees (38°C)?
2. In the last 14 days, have you been diagnosed with Coronavirus (COVID-19), or had any close contact with someone with a diagnosis of COVID-19?
3. Are you or anyone in your household showing signs of one or more of the following symptoms:
 - fever/chills/sweats
 - cough
 - sore throat
 - shortness of breath
 - nasal congestion/runny nose
 - myalgia (body aches)
 - loss of taste and/or smell
 - diarrhea
 - nausea
 - tiredness

Revised 8/31/2021

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