Volunteer/Student Intern Application

Your willingness to volunteer with the Oregon Department of Corrections is very much appreciated. In order to move the process of becoming a volunteer forward, please print clearly in black ink and provide complete and accurate information. Please fill out the entire Application. Mail your completed Application to the address below.

If you need more space than is provided to completely answer a question, you may attach additional sheets of paper to the back of this application.

If you have questions, please call the phone number listed below.

For Eastside Institutions, please mail completed Applications to:

Volunteer Program Representative
Two Rivers Correctional Institution
82911 Beach Access Road
Umatilla, OR  97882
Lavon.A.StarrMeyers@doc.state.or.us
(541) 922-2089

2/10/12
STATE OF OREGON
DEPARTMENT OF CORRECTIONS
Volunteer Program

VOLUNTEER/STUDENT INTERN
APPLICATION

☐ Student Intern  ☐ Functional Unit: ☐ Religious Services  ☐ Activities & Life Skills  ☐ A&D (12-Step)  ☐ Behavioral Health Services
☐ HGO  ☐ Admin  ☐ Reentry  ☐ Victim Services  ☐ Health Services  ☐ Education  ☐ Current or Past ODOC Employee or Contractor

Last Name: ______________________________  First: ________________________  Middle: ________________________

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<tr>
<th>Address: ___________________________________________</th>
<th>Home Phone: (______) ________ - __________________</th>
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<td>Driver’s License #: __________________ State: _____</td>
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<td>City: __________________________  State: _______</td>
<td>Date of Birth: <strong><strong>/</strong></strong>/______</td>
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Education (Please circle the highest completed):
- Elementary
- Middle-School
- High-School
- Associates
- Bachelors
- Masters
- Doctorate

Ethnic Origin (Please circle):
- Caucasian
- Hispanic
- African American
- Asian
- Native American
- Other ________________________________

Gender:  Male ☐  Female ☐

Height: ______ Ft ______ In  Weight: ________  Hair Color: ____________________  Eye Color: ____________________

Name of your Affiliation or Sponsoring Organization (PF, FITS, LDS, CCCF Quilters, Toastmasters, etc.)

Name: ____________________________________________

Address: ___________________________________________

City: __________________________  State: ____________

Zip Code: ________________________________

The contact person is someone in authority with your Affiliation or Sponsoring Organization who can verify that you are endorsed by the organization. It cannot be you or a relative.

Contact Person: ____________________________________________

Phone #: (______) ________ - ______________
Emergency Notification

Name: _____________________________ Daytime Phone: (_____) _______ - __________
Address: ___________________________ Evening Phone: (_____) _______ - __________
                                          Msg/Cell Phone: (_____) _______ - __________
City: ___________________ State: ______ Relationship: ___________________________

Name: _____________________________ Daytime Phone: (_____) _______ - __________
Address: ___________________________ Evening Phone: (_____) _______ - __________
                                          Msg/Cell Phone: (_____) _______ - __________
City: ___________________ State: ______ Relationship: ___________________________

Emergency Information

Physician: ___________________________ Phone: (_____) _______ - __________
Medical Conditions: ____________________________________________________________
Allergies: ____________________________________________________________________
Professional License:

If professional licensing is required (such as an RN or teaching certificate) for the volunteer work you will do, please provide the licensing information:

Type of License: __________________ License Number: ___________ Licensing Authority: ____________________
Address: ___________________________ City: __________________ State: ______ Zip: _______

Background Investigation Section

Please provide two references not related to you and not listed elsewhere in this application, whom you have known for more than one year, who can tell us about your qualifications and character. Listing names here constitutes permission to contact them and authorizes them to release information to us.

Name: __________________________________ Daytime Phone: (______) _______ - ___________
Address: __________________________________ Evening Phone: (______) _______ - ___________
________________________________________ Msg/Cell Phone: (______) _______ - ___________
City: ______________________ State: ______ Zip: __________

Name: __________________________________ Daytime Phone: (______) _______ - ___________
Address: __________________________________ Evening Phone: (______) _______ - ___________
________________________________________ Msg/Cell Phone: (______) _______ - ___________
City: ______________________ State: ______ Zip: __________

Where were you born? __________________________________________________ USA Citizen: ☐ Yes ☐ No
If no, country of citizenship: ______________________________ Are you in legal resident of the USA: ☐ Yes ☐ No

Please list States where you have lived and give the dates you lived there:_____________________

If you have ever been a crime victim, please give date(s) and name(s) of the person(s) committing the crime: _______

If you have ever been convicted of a crime, felony or misdemeanor (please exclude juvenile adjudications)? ☐ Yes ☐ No
If yes, please list them:

Date of Offense Offense (please be specific) Disposition (please be specific)

If you are a codefendant, list the name of the other defendant(s) ____________________________________________
## Background Investigation Section Continued

Are you currently on parole or probation?  □ Yes  □ No  If yes, please give details and your PO’s contact information:

______________________________________________________________________________________________________  
______________________________________________________________________________________________________  

Are you currently on an Oregon Department of Corrections inmate’s visiting list or are you related to, or a close friend of a Department of Corrections inmate?  □ Yes  □ No  If yes, please list the following:

Inmate’s Name: _________________________________  SID: _________________  Relationship: _________________

Inmate’s Name: _________________________________  SID: _________________  Relationship: _________________

Inmate’s Name: _________________________________  SID: _________________  Relationship: _________________

Other Names, Social Security Numbers, or Birth Dates You Have Used:  __________________________________________

______________________________________________________________________________________________________  

I understand that the Oregon Department of Corrections will verify the information in my application and that my failure to provide true, accurate and complete information is grounds for my disqualification from participating in the volunteer program as a volunteer or student intern or from doing a practicum.  I understand that accepting duties inside a department facility exposes me to potential hazards and risks that accompany exposure to adult felons and I will not hold the department liable.  I will abide by all Oregon Department of Corrections Rules, Policies, and procedural statements; and I will treat all information gained through my volunteer/student intern activities as confidential.  I further understand there will be no remuneration or compensation for the services I perform.  I have read the Code of Ethics and the Code of Conduct and I agree to abide by them.  I also agree to be photographed and fingerprinted.

Signed _________________________________________________     Date:  ________ / ________ / ________________

## FOR OFFICIAL USE ONLY

Date of LEDS: ________ / ________ / ________  Date of Reference Check: ________ / ________ / ________

VTS: Clear  □ Yes  □ No  Inmate Name and SID: __________________________________________

______________________________________________________________________________________________________  

LEDS Clear:  □Yes  □ No  SID: __________________  FBI: __________________  Approved: □Yes  □ No

Certified LEDS Operator: ________________________________   Signature: __________________
State of Oregon  
Department of Corrections  
Volunteer Program

Authorized State Volunteer Partial  
Waiver and Release of Rights Under the  
Oregon Tort Claims Act ORS 30.260-300

Please Print Your Name Here: ___________________________________________________

PLEASE READ CAREFULLY

As an authorized state volunteer performing activities on behalf of the State of Oregon Department of Corrections, I understand that the State of Oregon will provide limited medical and accidental death, dismemberment and disability coverage for me in the event I suffer injury due to an accident while performing volunteer or intern duties. In exchange for the coverage, I, for myself, my heirs, executors, administrators and assigns, release and forever discharge the State of Oregon from any and all demands or claims for damage or injury, from any cause or suit or action, known or unknown, that I may have against the State of Oregon and/or its officers, agents or employees, and from all liability under Oregon Tort Claims Act, ORS 30.260-300, for any and all harm or damage to my health in any manner resulting from, or arising out of my state volunteer or intern activities.

This release does not extend to, or waive any rights I may have under the Oregon Tort Claims Act, ORS 30.260-300, to defense and indemnification from any demand, claim suit or action brought against me or liability I may be subject to, or may arise out of my authorized state volunteer activities.

In the event that I am injured while performing state volunteer activities, I will notify my Department of Corrections supervisor and apply for injury coverage benefits.

_______________________________________________  ________/ ________/ ________  
Volunteer Signature           Date
As a person working in a State of Oregon agency, you need to understand the extent to which you are covered by State of Oregon insurance for liability and personal injury/illness. Please read the following carefully and sign below.

**TORT LIABILITY**
You will be protected from civil liability for injuries or damage to the person or property of other, subject to the following general conditions:

1. You are working on a state agency task assigned by an authorized agency supervisor;
2. You limit your actions to the duties assigned; and
3. You perform your assigned tasks in good faith, and do not act in a manner that is reckless or with intent to inflict harm to others.

The conditions and limits of this protection are as stated in the Oregon Tort Claims Act, ORS 30.260-300, and Oregon Department of General Services Risk Management Division Policy Manual, 125-7-201.

**MOTOR VEHICLE LIABILITY**
If you use a personally owned vehicle in the course of your duties, you are required to have automobile liability insurance to provide your primary coverage for any accidents involving that vehicle. State provided auto liability coverage will apply on a limited basis only after your primary coverage limits have been used.

**VOLUNTEER INJURY COVERAGE**
Workers Compensation is not provided. However, the agency has an injury protection plan to cover injuries of authorized volunteers. It is limited to only injuries due to an accident while performing volunteer duties. The state will pay medical treatment bills, disability, death and dismemberment benefits to the limits and under the terms and conditions described in Oregon Department of Administrative Services Risk Management Division Policy Manual, 125-7-204. If you are injured in a private vehicle, the owner=s insurance is responsible for your medical bills.

**REPORTING RESPONSIBILITY**
Anytime you are involved in any accident or exposed to a potential liability situation while performing assigned duties, you must inform the agency supervisor as soon as possible.

**ASSIGNED DUTIES**
Assigned duties are those listed on the Position Description Form.

*I HAVE READ AND UNDERSTAND THE ABOVE DUTIES AND CONDITIONS OF VOLUNTEER SERVICE.*

________________________________________________________________________

Volunteer Signature                                      Date

________________________________________________________________________