OPERATION Breakthrough

VOLUNTEER APPLICATION

Please circle one: Ms. Mrs. Mr. **Date:** _____/_____/_____

First:_____ MI: _____ **Last:** _____

Address:_____

_____

(City) (State) (Zip Code)

Home #: _____ **Cell #:**_____

E-mail Address: _____ **Date of Birth:** _____/_____/_____

Emergency Contact: _____

(Name) (Phone#)

How did you hear about Operation Breakthrough's Volunteer Program?

_____

Have you lived in a different state in the last 5 years? Yes No (If yes: List States _____)

Reason for Volunteering: _____

Number of Required Hours_____**Completed by** (date) _____/_____/_____

All volunteer hours are recorded and saved for future reference.

By signing below you understand the requirements of the volunteer program that you are applying for and commit to following them, and communicating with the volunteer department if something were to come up causing you to not keep your full volunteer commitment. You accept responsibility for all of your actions while at the center, traveling to and/or from the center, or engaged in any activity held by or for Operation Breakthrough. You understand that Operation Breakthrough cannot be held liable for any loss, personal injury, accident, misfortune or damage to yourself or your property.

_____ _____

Signature **Date**

_____

Signature of Parent/Guardian (if under 18)

For Internal Office Use Only

____Volunteer Application _____ BC ____ EL ____ FP Orientation Date: _____

____Volunteer Agreement ____ PS ____ TB ____ Shirt Size Start Date _____

____ RE Input Placement _____ Day_____ Time_____

OPERATION Breakthrough

VOLUNTEER AGREEMENT

FOR A BETTER UNDERSTANDING OF WHAT YOU CAN EXPECT AS A VOLUNTEER AND WHAT IS EXPECTED OF YOU BY OUR ORGANIZATION WE ASK THAT YOU READ AND SIGN THE FOLLOWING:

Volunteers play a vital role within our organization and will make a huge impact on the families and children of Operation Breakthrough through any volunteer effort. Volunteer positions will be assigned depending on center and staff needs that suit your interests and capabilities. The Volunteer Department greatly appreciates your voluntary services and will do it's very best to ensure that your volunteer experience is what interests you, is rewarding, productive, and safe.

Operation Breakthrough is one of the largest all in one childcare facility in the state of Missouri; 700 children call this center their home away from home 5 days a week all year round. The majority of families and children that we serve are living in poverty and have experienced multiple traumas in their lifetime. 1 out of 5 of our children are living in foster care, a shelter, or with a family member or friend. Our center is often the only stable environment that our children have, so we take extra precautions to ensure that every volunteer who interacts with our children and families understand the impact they have when introduced into their lives. We are looking for committed volunteers to believe in and support our mission.

We ask for your cooperation in adhering to the following guidelines:

- I understand that as a volunteer I am here to supply quality assistance to the children, teachers, and staff of Operation Breakthrough.
- I will support the Operation Breakthrough mission, and understand that as a volunteer I am a representative, on and off site, of this organization.
- If volunteering directly with children, I will attend a scheduled orientation, background check consent form, fingerprints, and commit to at least 1 Classroom shift every week for 12 weeks or 2x/month in MakerCity.
- I will respect and promote the unique identity of each child and family and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion, or disability.
- I understand that Operation Breakthrough cannot be held responsible for any damaged, lost, or stolen personal belongings.
- If volunteering with children I will use positive methods of child guidance and will not engage in any form of punishment. I understand that no child will be left alone or unsupervised while under my care and that all potential student discipline be referred to staff.
- I will follow Operation Breakthrough's dress code which means wearing a volunteer shirt, badge, and closed toed shoes when at the center in order to promote safety. Shorts/skirts must be knee length. No spaghetti strap shirts or muscle shirts will be allowed.

OPERATION Breakthrough

VOLUNTEER AGREEMENT (continued)

- I give my permission to Operation Breakthrough for the use and reproduction of any and all photographs, video or audio recordings taken of me while volunteering. All recorded media, prints; created media from the content shall be the property of Operation Breakthrough.
- I will not photograph any children without the approval of the Volunteer Coordinator; I must maintain confidentiality of all students and their family's information. I understand that cell phone use is not permitted while I am volunteering at the center.
- I understand that as a volunteer in this facility I am required to be a "Mandated Reporter" If I have any concerns or questions regarding the wellbeing of a child I will immediately notify the Volunteer Coordinator.
- I will keep my personal safety and the safety of all children and staff at the forefront of my volunteer activities. I will follow the rules and protocols presented to me, and will listen to staff's direction while volunteering.
- I will let the Volunteer Department know if they can improve the service and support that I receive. I will be open and honest and notify the department if I would like to change my role and/or commitment.
- I will not discuss my personal religious or political views while volunteering.

I have read and understand the guidelines and statements above, and agree to comply with them while I am a volunteer for Operation Breakthrough. I understand that I can be terminated as a volunteer at any time for any reason, and will be asked to leave the premises if I do not follow the above requirements.

_____

Print Name

_____

Signature **Date**

OPERATION Breakthrough

DISCLOSURE OF BACKGROUND INVESTIGATION

Operation Breakthrough, Inc. is providing to you this disclosure of our intent to conduct a background investigation for employment purposes. As a childcare services provider, Operation Breakthrough is required by law to perform background checks on individuals who work with or around children enrolled here prior to employment, annually and periodically throughout employment. This applies to volunteers and contractors as well. Under the Fair Credit Reporting Act (FCRA), any written, oral, or other communication of information provided by a Consumer Reporting Agency (CRA) is an investigative consumer report (background screening). Investigative consumer reports also include employment references, information about your personal characteristics, character, general reputation, mode of living, criminal, driving (if applicable) and work history.

Operation Breakthrough will request background investigations prior to employment, annually and periodically throughout employment from the following Consumer Reporting Agencies (CRAs): Missouri Department of Health & Senior Services Family Care Safety Registry (FCSR) and Missouri Volunteer and Employee Criminal History Service (MOVECHS). Their phone numbers are 1-866-422-6872 and 1-573-526-6153, respectively. The following criminal background checks will be included: child/elder abuse or neglect, sex offender registry check, and fingerprints to include both state and federal bureau of investigation criminal checks. A finding of any history of criminal conviction for a sexual offense or child/elder abuse will preclude you from working here. Other matters may prevent you from working here until further investigation and your history is cleared with the state of Missouri.

More information on the nature and scope of the investigation conducted by the CRA will be made available to you should you desire. Operation Breakthrough, Inc. will not provide you information from previous/ past employers, licensing agencies, educational institutions, volunteer agencies, or personal/ professional references not received from CRAs.

Please sign below to acknowledge your receipt of this disclosure.

_____

DATE OF SIGNATURE

_____ _____

PRINT FULL LEGAL NAME **SIGNATURE**

OPERATION Breakthrough

RELEASE AUTHORIZATION FOR BACKGROUND INVESTIGATION

In connection with your application to work at Operation Breakthrough as an employee or volunteer, you authorize Operation Breakthrough, Inc. and its background investigation service providers (Consumer Reporting Agencies), to procure and review background checks/consumer reports. You understand such reports will include information regarding state and federal criminal history or child/elder abuse or neglect, and your inclusion in any jurisdiction's registry of sexual offenders.

You also understand that your driving record (if appropriate to your duties), licensure in a specific profession, education, volunteer and employment history and other matters which reflect on your character and general reputation are a part of the background investigation.

The reports may be compiled from credit bureaus, court records, department of motor vehicles, past employers or volunteer service records, educational institutions, governmental license and registration entities, business or personal references, and any other source required to verify information.

The Consumer Financial Protection Bureau's Summary of Rights under the Fair Credit Reporting Act is provided in a separate written document. Your signature below acknowledges your receipt of the document.

You do hereby give consent (authorization) to Operation Breakthrough to request and receive such information prior to employment, annually and periodically throughout employment. You acknowledge that a fax, image, or copy of this authorization is as valid is as the original and good for one year.

_____ _____

PRINT FULL LEGAL NAME **SIGNATURE**

_____

DATE OF SIGNATURE

_____ _____

ADDRESS **CITY, STATE, ZIPCODE**

_____ _____

SOCIAL SECURITY NUMBER **BIRTH DATE**

Missouri State Highway Patrol
Criminal Justice Information Services Division

MOVECHS WAIVER AGREEMENT AND STATEMENT

Missouri Volunteer and Employee Criminal History Service (MOVECHS)
For criminal history record information pursuant to the *National Child Protection Act of 1993 (NCPA),* as amended by the *Volunteers for Children Act (VCA),*
And the *Adam Walsh Child Protection and Safety Act of 2006*

Pursuant to the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA), this form must be completed and signed by every current or prospective applicant, employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize Operation Breakthrough
Name of Qualified Entity

to submit a set of my fingerprints to the Missouri State Highway Patrol (MSHP) for the purpose of accessing and reviewing state and national criminal history records that may pertain to me. I understand that I would be able to receive any Missouri records pursuant to Chapter 43 RSMo from the MSHP, and any national criminal history record directly from the Federal Bureau of Investigation (FBI) pursuant to Title 28 Code of Federal Regulations (CFR) Sections 16.30–16.34, and that I could then freely disclose any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any Missouri and national criminal history record that may pertain to me to the qualified entity.

I understand that, until the criminal history background check is completed, the qualified entity may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, the qualified entity will provide me a copy of the criminal history background report, if any, received on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made.

☐ **Yes, I have** (OR) ☐ **No, I have not** been convicted of or plead guilty to a crime.
If yes, please describe the crime(s) and the particulars:

I am a current or prospective (check one): **Applicant** ☐ **Employee** ☐ **Volunteer** ☐ **Contractor/Vendor** ☐

Signature: _____ **Date:** _____

Printed Name: _____

Address: _____

Date of Birth: _____ **SSN (last 4 digits - Optional)** Not required

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TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: _____

Address: _____

Telephone: _____

NOTE: This document must be retained by the agency/qualified entity for audit purposes.

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

Patient's Name: _____ **Date of Birth:**_____ **Date:** _____
Address: _____ **Phone Number:** _____

A. Please answer the following questions (Sections A & B to be completed by Patient):	
Have you ever had a positive Mantoux tuberculin skin test (TST)?	☐ Yes ☐ No
Have you ever been vaccinated with BCG?	☐ Yes ☐ No
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐ Yes ☐ No
Have you ever been diagnosed with or treated for TB Disease?	☐ Yes ☐ No

B. <u>TB Risk Assessment</u>

Have you ever had close contact with anyone who was sick with tuberculosis?	☐ Yes ☐ No
Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.**	☐ Yes ☐ No
Were you born in one of the countries listed below? **If yes, please list the country:**_____ What year did you arrive in the United States? _____	☐ Yes ☐ No

Afghanistan	Cape Verde	Gabon	Kuwait	Myanmar	St. Vincent &	Tokelau
Algeria	Central African Rep.	Gambia	Kyrgyzstan	Namibia	The Grenadines	Tonga
Angola	Chad	Georgia	Lao PDR	Nauru	Sao Tome & Principe	Trinidad & Tobago
Anguilla	Chile	Ghana	Latvia	Nepal	Saudi Arabia	Tunisia
Argentina	China	Greenland	Lesotho	Nicaragua	Senegal	Turkey
Armenia	Colombia	Guatemala	Liberia	Niger	Serbia	Turkmenistan
Azerbaijan	Comoros	Guinea	Libyan Arab Jamihirya	Nigeria	Seychelles Sierra	Turks & Caicos
Bahrain	Congo	Guinea-Bissau	Lithuania	Niue	Leone	Islands
Bangladesh	Congo DR	Guam	Macedonia-TFYR	Northern Mariana	Singapore	Tuvalu
Belarus	Cote d'Ivoire	Guyana	Madagascar	Islands	Solomon Islands	Uganda
Belize	Croatia	Haiti	Malawi	Pakistan	Somalia	Ukraine
Benin	Djibouti	Honduras	Malaysia	Palau	South Africa	Uruguay
Bhutan	Dominica	Hungary	Maldives	Panama	Sri Lanka	Uzbekistan
Bolivia	Dominican Republic	India	Mali	Papua New Guinea	Sudan	Vanuatu
Bosnia & Herzegovina	Ecuador	Indonesia	Marshall Islands	Paraguay	Sudan - South	Venezuela
Botswana	Egypt	Iran	Mauritania	Peru	Suriname	Viet Nam
Brazil	El Salvador	Iraq	Mauritius	Philippines	Syrian Arab Republic	Wallis & Futuna
Brunei Darussalam	Equatorial Guinea	Japan	Mexico	Poland	Swaziland	Islands
Bulgaria	Eritrea	Kazakhstan	Micronesia	Portugal	Tajikistan	Yemen
Burkina Faso	Estonia	Kenya	Moldova-Rep.	Qatar	Tanzania-UR	Zambia
Burundi	Ethiopia	Kiribati	Mongolia	Romania	Thailand	Zimbabwe
Cambodia	Fiji	Korea-DPR	Morocco	Russian Federation	Timor-Leste	
Cameroon	French Polynesia	Korea-Republic	Mozambique	Rwanda	Togo	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://www.who.int/topics/tuberculosis/en/.

Have you ever had an abnormal chest x-ray suggestive of TB?	☐ Yes ☐ No ☐ No Response
Are you HIV positive?	☐ Yes ☐ No ☐ No Response
Are you an organ transplant recipient or donor?	☐ Yes ☐ No ☐ No Response
Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?	☐ Yes ☐ No ☐ No Response
Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?	☐ Yes ☐ No ☐ No Response
Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)?	☐ Yes ☐ No ☐ No Response
Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?	☐ Yes ☐ No ☐ No Response
Are you coughing up blood or phlegm?	☐ Yes ☐ No ☐ No Response

I hereby certify that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ _____
Patient Signature (Required) Date:

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)

Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.

1. **Tuberculin Skin Test (TST) -** Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm)of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____
Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____

***TST Interpretation Guidelines (Please check all that apply).**

>5 mm is Positive:
- ☐ Recent close contacts of an individual with infectious TB
- ☐ Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- ☐ Organ transplant recipients
- ☐ Immunosuppressed persons: taking ≥ 15 mg/d of prednisone for ≥ 1 month; taking a TNF-α antagonist
- ☐ Persons with HIV/AIDS

>15 mm is Positive:
- ☐ Persons with no known risk factors for TB disease

> 10 mm is Positive:
- ☐ Persons born in a high prevalence country or who resided in one for a significant amount of time
- ☐ History of illicit drug use
- ☐ Mycobacteriology laboratory personnel
- ☐ History of resident, worker or volunteer in high-risk congregate settings
- ☐ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
- ☐ Children < 4 years of age
- ☐ Children and adolescents exposed to adults in high-risk categories

2. **Interferon Gamma Release Assay (Please check the IGRA that is used)**
   QFT-G ☐ QFT-GIT ☐ **Date Obtained**: _____
   Result: ☐ Responsive (TB Infection Likely) ☐ Nonresponsive (TB Infection Unlikely) ☐ Indeterminate
   T- Spot ☐ **Date Obtained**: _____
   Result: ☐ Negative ☐ Positive ☐ Borderline/Equivocal
   Other: _____ **Date Obtained**: _____ **Result:**_____

3. **Chest X-ray: (Required if TST or IGRA is positive)**
   Date of Chest X-ray: _____ **Result:** ☐ Normal ☐ Abnormal
   Abnormal Chest X-ray Interpretation: _____

4. **Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis,** please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.

1. Date Obtained	Smear Result:	Culture Result:	2. Date Obtained:	Smear Result:	Culture Result:
_____	_____	_____	_____	_____	_____
3. Date Obtained:	**Smear Result:**	**Culture Result:**			
_____	_____	_____			

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory, for further testing questions call 573-751-3334.

I have reviewed the above information with the patient and deemed: ☐ **No Further Evaluation Needed** ☐ **Further Evaluation is Needed**

_____ _____
Health Care Provider Signature (Required) Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

Patient may:
- ✓ Have contact with children (infant through school-age) in care away from their own homes.
- ✓ Be responsible for children's physical care and social development during day and/or nighttime hours.
- ✓ Need to lift children.

IDENTIFYING INFORMATION (To be completed by patient.)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER
	( )
NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED	

MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)

PHYSICAL EXAMINATION

On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. ☐ Yes ☐ No

TB CLEARANCE

(Check one.)

☐ TB Risk Assessment Form attached (required)

☐ A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____ .

LIMITATIONS

The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:

☐ None

☐ _____

RESTRICTIONS

This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.

☐ None

☐ _____

REMARKS

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)
NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE)		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.)
		TELEPHONE NUMBER
		( )