INTERN/VOLUNTEER PROGRAM APPLICATION PACKET
2016/2017

APPLICATION INSTRUCTIONS

Thank you for your interest in our intern and volunteer opportunities at SJB Child Development Centers.

Please review the instructions for the Intern/Volunteer Program:

1. Submit the Intern/Volunteer Application packet:

   - ☐ Intern/Volunteer Application
   - ☐ Emergency form
   - ☐ Volunteer Release & Waiver of Liability
   - ☐ TB test conducted within 1 year of application date
   - ☐ Fingerprints Clearance* (LiveScan if applicable)
   - ☐ Copy of Driver's License

   *Fingerprinting is required for volunteers and interns who are recording 15 or more hours a week. Contact volunteer@sjbcdc.org for the location and address of the Fingerprinting facility.

   a) Generally, the results are recorded 3-7 business days after the fingerprinting is conducted. You will be required to request Fingerprinting results from our local Licensing department at (408) 324-2148.
   b) Contact Human Resources with your Fingerprinting results at 408 414-2700 or volunteer@sjbcdc.org.

2. Once the application packet is reviewed and approved by Human Resources and the Program department, the applicant will be contacted by a SJB CDC representative to coordinate a schedule.

We thank you for your cooperation, while we process your application, and look forward to working with you soon.

Please email or fax your forms to the Administrative Office.

E-Mail: volunteer@sjbcdc.org
Phone: 408.414.2700
Fax: 408.521.0242 (Attention Human Resources)
Website: www.sjbcdc.org

INTERN/VOLUNTEER APPLICATION

The mission of SJB Child Development Centers is to provide educational child care for children 0 to 12 years of age to strengthen and support families throughout Santa Clara County.

SJB Child Development Centers complies fully with state and federal laws prohibiting discrimination because of age, race, color, religion, sex or national origin. Further, SJB Child Development Centers takes affirmative action to assure that its policies and practices relative to equal opportunity are enforced.

Thank you for your interest in SJB Child Development Centers.

NAME: LAST		FIRST		MIDDLE INITIAL		
PRESENT ADDRESS: NO.	STREET	APT. NO.	CITY	STATE	ZIP	
PRIMARY PHONE: ☐HOME ☐MOBILE ( )	EMAIL ADDRESS:		ARE YOU BILINGUAL? ☐ YES ☐ NO IF YES, WHAT LANGUAGES			
ARE YOU AT LEAST 18 YEARS OF AGE? ☐ YES ☐ NO	HAVE YOU EVER VOLUNTEERED FOR SJB CDC? ☐ YES ☐ NO IF YES, DATE(S): ASSIGNMENT:					
ARE YOU INTERESTED IN EMPLOYMENT OPPORTUNITIES? ☐ YES ☐ NO						
	NAME OF SCHOOL AND ADDRESS		DEGREE OR DIPLOMA		FIELD OF STUDY	
COLLEGE						
OTHER (SPECIFY)						
OTHER SPECIALIZED TRAINING, SKILLS, CERTIFICATIONS						
PRINT NAME		SIGNATURE			DATE	
IF APPLICABLE:						
INSTRUCTOR NAME		SIGNATURE			DATE	
SITE REQUESTED						
FOR OFFICE USE ONLY:						
SITE ASSIGNED						

EMERGENCY FORM

Personal Information		
First Name		Birth date
Last Name		
Home Address City, State, Zip		
Home Phone		Cell Phone
Email Address		

Emergency Contact 1		
Emergency Contact's Name		
Relationship		
Address City, State, Zip		
Phone Number(s)	Cell	Home
	Work	Other

Emergency Contact 2		
Emergency Contact's Name		
Relationship		
Address City, State, Zip		
Phone Number(s)	Cell	Home
	Work	Other

Authorization

In case of accident or acute illness, I authorize SJB CDC to arrange transportation and to arrange for possible emergency medical and/or surgical care at the closest hospital. I also authorize SJB CDC to notify my listed emergency contact(s).

Signature: **Date:**

Volunteer Release & Waiver of Liability

Name _____

Home Address _____

Home Phone _____

Personal Email _____

❒ Yes, I would like to receive the SJBCDC Newsletter.

Confidentiality Disclaimer

As a volunteer with SJB Child Development Centers (SJBCDC) all information obtained during my volunteer service is private and confidential. I shall not share any information with others regarding our children and families outside the organization.

I understand that safety is an important part of my job and that I will do everything possible to embrace safety for myself and for the children and families I work with.

Liability Disclaimer

As a volunteer with SJBCDC all services are voluntary and as such I hereby waive all claims for injury, damage, or loss to my person or property which may be caused directly or indirectly, by any act, omission, or negligence arising from or related to the activities with SJBCDC. I hereby release and forever discharge and hold harmless SJBCDC and their officers, directors, agents or otherwise. I also understand that SJBCDC does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.

Media Release Waiver

I agree that SJBCDC may take photographs and allow the use of my image in all related marketing materials, which may include but are not limited to brochures, newsletters, video, print ads, websites, and emails. I understand that SJBCDC may share these images with its affiliates, other non-profits and foundations for their use in reports and other marketing materials. I understand that SJBCDC has the right to edit, crop or adjust the images at its discretion. I understand that I will not be compensated for such images, and I agree not to make any claims against SJBCDC or its associates, relating to or arising out of the taking of such images or any use of such images by SJBCDC or hired media professionals.

_____ _____

Date Volunteer/Intern Signature

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME: SJB Child Development Centers

FACILITY ADDRESS: 1400 Parkmoor Ave. SJ CA 95126

PERSON'S NAME		AGE
POSITION TITLE	TYPE OF FACILITY: Child Care	WORK DAYS PER WEEK / WORK HOURS PER DAY

DUTY STATEMENT: TB TEST ONLY

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☑ Infants
- ☑ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☑ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶	ADDRESS	DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	☐ POSITIVE ☐ NEGATIVE	ACTION TAKEN (IF POSITIVE)
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)	DATE
HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶	**TELEPHONE #**	**DATE**

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✔ one)*
☐ Adult Resident other than Client ☐ Employee ☐ License, Certification, Applicant ☑ Volunteer

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility Type."
Child Care Center

4. Agency Address Set Contributing Agency:

CA Dept of Social Services			**03502**
Agency authorized to receive criminal history information			Mail Code *(five-digit code assigned by DOJ)*
PO BOX 944243	**Mail Station 9-15-62**		**N/A**
Street No.	Street or PO Box		Contact Name *(Mandatory for all school submissions)*
Sacramento,	**CA**	**94244-2430**	**( ) N/A**
City	State	Zip Code	Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* _____
LAST FIRST MI

AKA's: _____
LAST FIRST

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. BIL - _____
AGENCY BILLING NUMBER *(IF APPLICABLE)*

HT: _____ WT: _____

Misc. No.: _____
ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.

EYE Color: _____ HAIR Color: _____

Home Address: *(All applicants must complete)*

POB: _____

_____
STREET OR PO BOX

SOC: _____
(See Privacy Statement on Page 4)

_____
CITY, STATE AND ZIP CODE

6. Facility Number: 430703695 Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No. _____

7. Employer: (*Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only*)

SJB Child Development Centers			
Employer Name			
1400 Parkmoor Ave. Suite 220			
Street No.	Street or PO Box		Mail Code *(five digit code assigned by DOJ)*
San Jose	CA	95126	408 414-2700
City	State	Zip Code	Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency	LSID#	ATI No.	Amount Collected/Billed

GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING
Instructions for the LIC 9163

1. **Originating Response Indicator (ORI):** Preprinted

2. **Working Title:** Check the appropriate box

3. **Authorized Applicant Type:** Indicate the facility type where you will be working.

   Select your licensed facility type from the left column, and in the right column find its corresponding DOJ abbreviated facility type. **Enter the corresponding DOJ abbreviated facility type on this line.**

Note: In the following table you may be able to identify yourself with more than one facility type within each category. Please select only one facility type in any category using the facility that you are most associated with on a day-to-day basis.

If this is your applicable facility type ⇨ **Enter this abbreviated facility type on your application.**

CCLD Facility Type by Category	DOJ Abbreviated CCLD Facility Type
Adult Day Care Facility Adult Day Support Center Adult Residential Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Cent more/6 Child
Family Child Care Home	Family Day Care
Foster Family Agency Foster Family / Adoptions Agency Foster Family Agency Sub Office	Foster Family / Adopt Emp.
Foster Family Agency - Certified Home Foster Family Home	Foster Family Home
Group Home (6 or less children)	Group Home 6 / child less
Group Home (7 or more) Community Treatment Facility	Group Home more / 6 child
Residential Care Facility for the Chronically Ill Residential Care Facilities for the Elderly	Residentl Care Fac Elderly
Small Family Home Transitional Housing Placement Program	Resid Child Care 6 / less
Social Rehabilitation Facility	Adult Day / Resident / Rehab

4. **Agency Address Set Contributing Agency:**

Agency authorized to receive criminal history information:
The following information is pre-printed:
Agency: CA Dept of Social Services **Mail Code:** 03502

Street No.: P.O. BOX 944243, M.S. 9-15-62 **Contact Name:** N/A

City, State, Zip: Sacramento, CA 94244-2430 **Contact Telephone No.:** N/A

5. **Applicant Information:** Print your full name (last, first, middle initial).

AKA's: Other names the applicant has used **CDL No:** CA Drivers License or CA ID

DOB: Date of Birth **SEX:** Male or Female **MISC No: BIL -** Enter the agency billing number, if applicable

HT: Height **WT:** Weight **MISC No.:** Enter any other identification numbers (ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: Color of eyes **HAIR Color:** Color of hair **Home Address:** Applicant's home address

POB: State or Country of Birth

SOC: Social Security Number (optional) (See Privacy Statement on Page 4)

6. **Facility Number:** Enter the facility number or assigned OCA number (Agency Identifying Number).

Level of Service: Preprinted
Note: If a Child Abuse Central Index (CACI) check is required, it will automatically be completed by DOJ and all applicable fees will be charged. There is no entry necessary on the applicant's part.

If resubmission for fingerprint quality, list Original Applicant Tracking Information (ATI) No.: If your fingerprints were rejected and this is a resubmission of your prints, enter the original ATI number provided on the reject notice to avoid paying an additional processing fee.

7. **Employer:** Enter the facility name and address for which you are being printed.

Employer Name:	Enter the facility name.
Street No.:	Enter the facility address.
Mail Code:	Enter the facility mail code (if applicable).
City, State, Zip:	Enter the facility city, state and zip.
Agency Telephone No.:	Enter the facility phone number.

8. **Live Scan Transaction Completed By:** This section will be completed by the Live Scan operator.

Take this form with you the day you are fingerprinted. The Live Scan Operator will complete section 8. If the Live Scan Operator is IBT - L1, they will return the completed form to you. Retain this form for your records.

If you use a Live Scan Operator other than IBT - L1, you will need to take 2 copies of this form. One copy will be retained by the Operator and the other you may retain for your records.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.