



Dear Prospective Medical Volunteer,

Thank you for your interest in volunteering at The Laurel Foundation's Camp Laurel program. We appreciate the time you are taking out of your busy schedule to learn more about our organization.

The Laurel Foundation is a registered 501 (C)(3) non-profit organization. The Laurel Foundation's educational and support programs are designed to improve the quality of life of over 500 children, youth and families affected by HIV/AIDS each year. The mission of The Laurel Foundation is to empower children, youth and families affected by HIV/AIDS through educational and support programs in a safe and trusting environment.

Ensuring the safety of our children is Camp Laurel's number one priority. Keeping that in mind, we trust you will understand the need for the detailed information we request from each applicant. We understand the application process is lengthy and ask for your patience as you are completing the required paperwork. Again, our goal is to ensure the safety of our campers by selecting the most qualified volunteers for our programs.

Thank you for taking the first step towards becoming a Camp Laurel volunteer. We truly appreciate your interest in serving children, youth and families living with HIV/AIDS.

Please contact us at (626) 683-0800 or by e-mail at LFranklin@Laurel-Foundation.org, should you have any questions regarding the application process. You may also visit www.Laurel-Foundation.org to learn more about our organization.

Please send this application to:

The Laurel Foundation
75 S. Grand Avenue
Pasadena, CA 91105
Fax: (626) 683-0890
Email: LFranklin@Laurel-Foundation.org

Best regards,

Lauren Franklin
Director of Volunteers



Volunteer Medical Staff Job Description
PLEASE READ CAREFULLY

Minimum Qualifications:

- LVN, RN, NP, PA or MD with current California medical license
- Desire and ability to work with children in the outdoors (prior experience working with children desirable)
- Have no hesitations about working with children, adolescents or adults with HIV/AIDS
- Ability to relate to one's peer group and work well with people from diverse backgrounds
- Ability to accept supervision, guidance and constructive feedback
- A positive role model for children and peers (exemplary character, good judgment, approachable, etc.)
- Possess enthusiasm and patience
- At least 18 years of age
- Emotional stability to endure stressful situations, think critically and calmly resolve conflict
- Must be a US or Canadian citizen or a lawful legal resident of the US for at least 10 years

Essential Functions:

- Administration of medications that are prescribed to a campers, volunteers, or staff members by a licensed practitioners; this includes all prescription and over-the-counter medications
- Assess and provide treatment for acute injuries/illnesses (as allowed by license)
- Participate in activities and evening programs with campers as assigned by Medical Director, including an overnight tent camping trip during Summer ant Teen Camp
- Capacity to deal with highly stressful (physically and emotionally) situations with composure
- Ability to abstain from all phone usage (except in the event of an emergency) for the duration of camp session

Major Responsibilities:

- Maintain health and safety of all campers and staff
- Help each camper meet the camp goals, including increased self-esteem
- Provide guidance and encouragement for camper participation in activities
- Interact with assigned cabins as assigned
- Communicate openly with staff to ensure effective resolution of conflicts
- Participate actively in staff meetings, training, and supervisory conferences
- Adhere to all of Camp Laurel's policies and regulations
- Be a positive role model who sets a good example for campers and peers

Benefits:

- Personal growth and satisfaction
- Developing sustained friendships with people from diverse backgrounds who share a common goal of wanting to make a positive impact on the lives of children, adolescents and adults living with HIV/AIDS
- Receive consistent direction, support, supervision and training from professional staff
- Opportunity to enhance interpersonal communication and leadership skills

I hereby agree that I have read and understand the above. I do not have any limitations that would hinder my ability to safely perform any of the duties or essential functions of a The Laurel Foundation volunteer. **Initial** _____



2016 Volunteer Medical Staff Application

Personal Information: <i>The Laurel Foundation is an Equal Opportunity Organization. Please Print Clearly</i>					
Name (Last, First, Middle):				Gender: M _____ F _____	
Current Address (Street, City, State, Zip): <i>Address Valid until:</i>					
Please list addresses for the last 5 years (if different from above, attach additional sheet if necessary)					
Permanent Address (if different from above):					
Email:			How long have you lived at current address?:		
Phone #:			Cell #:		
How did you hear about Camp Laurel?					
Driver's License #:		State:		Expiration Date:	
Are you a US or Canadian citizen, or have you been a lawful legal resident in the US for at least 10 years? Yes _____ No _____ <i>In order to volunteer with The Laurel Foundation, you must be a US or Canadian citizen, or a lawful legal resident of the US for at least 10 years. This policy is in place because we are only able to perform background checks on US or Canadian citizens.</i>					
May we release the following to other volunteers and medical staff: Email Address: Yes _____ No _____ Telephone #: Yes _____ No _____ Address: Yes _____ No _____					
Have you ever worked with individuals with HIV/AIDS? Yes _____ No _____ Do you have any hesitations about working with individuals with HIV/AIDS? Yes _____ No _____					
Do you speak any language(s) other than English? _____					
What contributions do you think you can make to children at Camp Laurel? Use additional sheet if necessary.					
Dietary Needs:					
Do you have any special dietary needs? This selection will pertain to all meals served during camp session.					
None _____		Vegetarian _____		Vegan _____	
Other _____					
Please check the 2016 camping session you are applying for: Please mark which dates you can attend:					
____ Spring Family Camp: May 5 - 8 (kids 3-17 and families)			____ Summer & Teen Camp: August August 19 - 24 (kids 6-17)		
Office Use Only	Date Received _____		<input type="checkbox"/> Photo ID		<input type="checkbox"/> Medical License
	Camp Forms _____		RSOC _____		TB _____
		BC _____		Phys _____	
		Ref: 1 2 3			



Experience working with youth: List any past experience working with youth or HIV/AIDS.		
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:

Educational Background:			
Name and Location	# of years completed?	Did you graduate?	Course of Study:
High School:			
College:			
Other:			

Medical Employment History: Please provide the following information for your past 3 employers or assignments starting with most recent.		
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:
From-To (date):	Employer Name: Address: Phone:	Supervisor & Title:
Position Title & Job Responsibilities:		May we contact for reference? Y ___ N ___
		Reason for leaving:



Professional Status:

The following questions pertain to any action, including any investigation which has EVER been undertaken, whether completed or still pending which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal, voluntary relinquishment by resignation or expiration (including relinquishment that was bargained for) of your medical staff membership, privilege, licensure, certification or status as a student in good standing.

If the answer to any of the following questions is YES, please give full details on a separate sheet of paper.

A. Has your license to practice medicine, in any state, and/or your Drug Enforcement Administration registration, in any state, ever been limited, suspended, revoked, voluntarily relinquished, or is such action pending?	Yes	No
B. Have your privileges or status at any hospital, health care facility or practice organization ever been suspended, diminished, revoked, not renewed, voluntarily relinquished or is any such action pending?	Yes	No
C. Have you ever been denied membership or renewal thereof on the basis of formal peer review or been subject to disciplinary action or any medical organization (e.g., medical staffs, HMOs etc.) or is any such action pending?	Yes	No
D. Have you ever resigned or surrendered clinical privileges from a medical staff while under investigation for possible incompetence or improper professional conduct or in return for such an investigation not being conducted?	Yes	No
E. Were you ever subject to any disciplinary action during your status as a student in any internship, residency, fellowship, preceptorship, or other clinical educational program?	Yes	No
F. Has your membership or fellowship on any local, county, state, regional, national or international organization ever been suspended, diminished, revoked or not renewed, or is such action pending?	Yes	No
G. Has your professional school faculty position or membership ever been suspended, diminished or revoked, or is such action pending?	Yes	No
H. Has your Specialty Board Certification ever been denied, suspended, diminished or revoked, or is such action pending?	Yes	No
I. Have you ever been notified of any investigation or to appear before any licensing agency for a hearing or complaint of any nature?	Yes	No
J. Has any action, including any investigation, been undertaken, whether still pending or completed, or against you by any governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements.	Yes	No
K. Are there any current, past or pending criminal charges against you, except for minor traffic infractions?	Yes	No
L. Are there any prior or pending third party proceedings or litigation challenging or sanctioning your patient admissions, treatment, discharges, charging, collection or utilization practices?	Yes	No

Physical and Mental Health Status:

A. Are you able to perform all the procedures for which you have requested privileges with or without reasonable accommodation, according to accepted standards or professional performance and without posing a direct threat to patients?	Yes	No
<i>If you answer YES to B and/or C, please give full details on a separate sheet of paper.</i>		
B. Have you ever become aware of or were you ever advised that you had any temporary or permanent physical or mental condition or impairment which might interfere with your ability to practice your profession with reasonable skill and safety, other than any such condition or impairment which you have indicated in the previous question?	Yes	No



Current Professional Liability Insurance: (Please attach proof of professional liability insurance)

Do you currently have professional liability insurance? Yes _____ No _____

Professional Liability Insurance Carrier:

Policy #: _____ Max. Occurrence/ Max Aggregate: _____

Address: _____

City, State, Zip: _____ Expiration Date: ____/____/____

Other Liability Claims: List on a separate page all other liability insurance policies you have had within the last 10 years, other than the one listed above. Include the carrier name, address, policy number and coverage date.

A. Have any professional liability claims been filed against you, have you reported any malpractice claim to your insurance carrier, or have you received any letter of intent to sue?	Yes	No
B. Are any professional liability claims pending against you?	Yes	No
C. Has any settlement been made or any judgement entered against you in any professional liability case in which you or a professional liability insurance carrier had to or agreed to make a monetary payment of any amount.	Yes	No
D. Have you been denied professional liability insurance, has your policy been canceled has your professional liability insurer refused to renew your policy or placed limitation on the scope of your coverage, or has any professional liability carrier expressed any intent to deny, cancel, not renew or limit your professional liability insurance or its coverage, or rated up because of unusual risk?	Yes	No

Signature: _____ **Date:** _____

Certifications: ****Please send a copy of your medical license (both sides) with this application****

License #:	State of License: <small>(You will need an active CA license)</small>
DEA #:	# of years practicing:

Medical Requirements:

All volunteers must have a **TB test** and **medical check up** within 12 months prior to the camp session. If selected, will you provide The Laurel Foundation with a copy of your TB test and medical check up certifying that you will not pose a health risk to campers or other staff (e.g., do not suffer from any contagious diseases)?

Yes _____ No _____

Professional References: Please **DO NOT** list current employer(s) or relatives. This section must be completely filled out.

1. Name:	Occupation:	Phone:
Address:		
2. Name:	Occupation:	Phone:
Address:		
3. Name:	Occupation:	Phone:
Address:		



Smoking Policy: The Laurel Foundation strives to hire volunteers who are role models for the children. In keeping with this, smoking will only be allowed in a designated area, upon completion of nightly staff meetings, and only when permitted by the site. We trust you will understand this policy.

Conditions of Employment:

1. In consideration of the acceptance of my application for participation at the camp session, I hereby waive, release and discharge any and all claims for damages for death, personal injury or property damage which I may have, or which may hereafter accrue to me, as a result of my participation in the camp's activities and its not for profit parent company, any and all of their agents, representatives and volunteers and employees. This release is intended to discharge in advance the camp, The Laurel Foundation from any and all liability, claims, costs, expenses and/or damages (collectively referred to as "liability") arising out of or connected in any way with my participation in the activities of The Laurel Foundation, even though that liability may arise of of negligence or carelessness on the part of the persons or entities mentioned above. I further understand that serious accidents occasionally occur during camp activities, and that participants in the camp activities occasionally sustain mortal or serious personal injuries and/or property damage as a consequences thereof. Knowing the risks of camp, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who (through negligence or carelessness) might otherwise be liable to me (or to my heirs or assigns) for damages.

2. I understand that during any camping experience involving community and/or environmental living there are inherent health risks, including but not limited to exposure to illnesses, childhood or otherwise, to which I may not have been previously immunized against. Further, I understand that The Laurel Foundation has made every reasonable attempt to minimize these health risks; however, should I experience any illness following any Laurel Foundation program, I should contact my physician or call The Laurel Foundation office (626) 683-0800 to consult with the medical staff.

3. The Laurel Foundation accepts no responsibility for the loss, damage, or theft or volunteers' property.

4. Volunteer must complete this form to attend camp.

Signature:

Date:

Print name: