



Dear Prospective Volunteer:

Thank you for your interest in volunteer opportunities at United Cerebral Palsy Association of Greater Suffolk. Volunteers provide meaningful service to our programs.

Enclosed are the Volunteer Application, the Volunteer Conduct Requirements and Release Forms for your review. All of these forms must be completed and returned to me at the address below. Please be advised that all volunteer applicants are required to have a Tuberculosis Test, Substance Abuse Screening and are subject to a Criminal History Check in order to complete the application process. Volunteers under the age of 18 must have a parent or guardian sign the three Release Forms.

Upon receipt of your completed application, I will forward it to the department(s) of interest. The manager of the department may call you if further clarification is needed. When a volunteer service match is agreed upon, you will be contacted to come to United Cerebral Palsy Association of Greater Suffolk, Hauppauge for testing instructions and additional required forms. All testing results must be completed before a final service decision can be made.

Once a service determination is finalized, an orientation of one or more hours may be needed to provide specific disability and departmental safety information.

If you have computer access, you might also want to view our web site www.ucp-suffolk.org for information about our services and programs.

Thank you again for your interest and feel free to call me at 543-4500 ext. 218 if you have further questions.

Sincerely,

Elizabeth Weston

Elizabeth Weston
Training Specialist

Attachment



VOLUNTEER APPLICATION

Thank you for your interest in volunteer opportunities at United Cerebral Palsy Association of Greater Suffolk. Please complete the personal information questionnaire required by law in the State of New York for all volunteers seeking placement in a non-profit organization. It will assist us in our efforts to match your skills to current volunteer needs.

Please Print Information Clearly

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: H () _____ W () _____ e-mail: _____
Age: Under 18

Where did you hear about UCP and our volunteer opportunities? _____

Person to be contacted in case of emergency or illness:

Name: _____
Address: _____
Phone: H () _____ W () _____ Other () _____
Relationship: _____

Education: (Please circle highest level attained)
High School GED College 1,2,3,4, Graduate School Other: _____

Current Employment/Profession: _____

Please list related experience / work skills including volunteer, internships or special training:

VOLUNTEER APPLICATION *Continued*

Please Print Information Clearly

Do you require any reasonable accommodations to perform this volunteer position? NO YES

Have you been convicted of a crime including a felony or misdemeanor? NO YES

If YES, please explain: _____

Please provide two personal or professional references:

Name	Relationship	Phone Number(s) / e-mail etc.

Using the list of Agency Program Descriptions attached, please number those that interest you beginning with the number 1 to indicate your first priority:

- | | |
|--|---|
| _____ Education - The Children's Center | _____ Community Day Habilitation Services |
| _____ Day Treatment Program | _____ Residential Program |
| _____ Development/Public Relations | _____ Diagnostic & Treatment Center |
| _____ Vocational Rehabilitation Programs | _____ Sports Team |

When are you available to volunteer? Please indicate times in boxes (*example: 9:00 to 11:00*)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Signature: _____ Today's Date: _____

*Thank you for taking time to complete this application.
 Upon receipt, it will be forwarded to departments that interest you. Shortly thereafter, you'll be contacted if an immediate skill-match opportunity is open. Otherwise your application will be retained for future volunteer opportunities, as they become available.*



VOLUNTEER CONDUCT REQUIREMENTS: 633.7 REGULATION

1. Volunteers shall not engage in any activity that constitutes abuse of individuals as defined in the Regulations of the Commissioner. “**Abuse** – the maltreatment or mistreatment or mishandling of an individual which would endanger the physical or emotional well-being of the individual through the action or inaction on the part of any person including an employee, volunteer, consultant, contractor, visitor or other, whether or not the individual is or appears to be injured or harmed. The failure to exercise one’s duty to intercede on behalf of an individual also constitutes abuse.” (624.4b)
2. There shall be no use of corporal punishment upon individuals. “**Punishment, corporal** – the use of physical force upon an individual for the purpose of disciplining or chastising that individual.”
3. There shall be no discriminatory activity against individuals or others for any reason including race, religion, national origin, creed, age, sex, ethnic background, developmental disability, AIDS or HIV status.
4. Volunteers shall not distribute, sell, possess, purchase or consume illegal substances or alcohol while at the workplace or while performing in a work-related capacity. However, the consumption of alcohol on special occasions shall be permitted with prior written permission of the Executive Director.
5. Volunteers shall not come to work, or work, if their ability to perform their job is impaired due to the use of alcohol, a controlled substance, an illegal substance, or a prescribed medication.
6. Program participants shall not carry out the duties of volunteers unless such tasks are described in the individual’s program planning team for the purpose of increasing that individual’s skills.
7. Individuals shall not be subject to inappropriate exposure to firearms or other weapons in or on the grounds of the Agency. No firearms or weapons are permitted on the grounds of the Agency.
8. There shall be no personal financial transactions between volunteers and program participants, which may be construed as client exploitation or result in greater benefit to the employee than the individual.
9. Volunteers shall not model inappropriate or unacceptable behavior to an individual.
10. Volunteers shall treat program participant’s information as confidential and utilize such information in a professional manner at all times. To the extent volunteers obtain HIV-related information concerning a person, such information shall be maintained in confidence.

I have read the above “Volunteer Conduct Requirements,” and I understand my conduct requirements while functioning in a work-related capacity.

Volunteer Signature

Date



Dear Prospective Volunteer:

The New York State Health Department and the New York State Office For People with Developmental Disabilities (OPWDD) require all volunteers to have a yearly tuberculosis screening.

The only acceptable method of administration of the tuberculosis skin test is the two-step PPD that involves the introduction of a purified protein derivative (PPD) into the skin by intradermal injection, and read within 48 to 72 hours. A second test is administered (as long as there was a negative reaction to the initial skin test) one to three weeks later. All volunteers must have the PPD screening or submit documentation that a screening has been completed within the last twelve months. United Cerebral Palsy Association of Greater Suffolk can administer this test, if necessary.

Please contact Elizabeth Weston as noted on the cover letter, if you have any questions or concerns. Thank you for your interest in volunteering at United Cerebral Palsy Association of Greater Suffolk.

Sincerely,

Nursing Department

Nursing Department



RELEASE FOR MANTOUX TEST

If you are under eighteen (18) years of age, please have your parent or guardian complete and sign the bottom of this letter if you are going to receive your two-step PPD test at United Cerebral Palsy Association of Greater Suffolk.

This signed release **must** be submitted with your application to allow United Cerebral Palsy Association of Greater Suffolk to administer your two-step PPD test.

I hereby give permission for _____, to have the two-step PPD test administered by United Cerebral Palsy Association of Greater Suffolk.

Signature of Parent/Guardian

Date



RELEASE FOR DRUG SCREENING

United Cerebral Palsy Association of Greater Suffolk is firmly committed to ensuring a safe, healthy, productive and efficient work environment for our employees, program participants, volunteers, and to the public in general.

United Cerebral Palsy Association of Greater Suffolk has a vital interest in ensuring a safe, healthy and efficient working environment and in preventing accidents and injuries from misuse of alcohol or drugs. The unlawful or improper presence or use of drugs or alcohol in the workplace presents a danger to everyone.

If you are under eighteen (18) years of age, please have your parent or guardian complete and sign the bottom of this letter.

This signed release **must** be submitted with your application to allow United Cerebral Palsy Association of Greater Suffolk to proceed with preparing you to receive your Drug Screening Test. You will be contacted, given an appointment to come to United Cerebral Palsy Association of Greater Suffolk, Hauppauge and provided with additional documents at that time.

I hereby give permission for _____, to have United Cerebral Palsy Association of Greater Suffolk, Inc. proceed with the drug screening process.

Signature of Parent/Guardian

Date



RELEASE FOR FINGER PRINTING
CRIMINAL HISTORY RECORD CHECK

United Cerebral Palsy Association of Greater Suffolk is firmly committed to ensuring a safe, healthy, productive and efficient work environment for our employees, program participants, and volunteers and to the public in general.

United Cerebral Palsy Association of Greater Suffolk is required / authorized by New York State Law to request a check of criminal history records and to review results of those record checks.

If you are under eighteen (18) years of age, please have your parent or guardian complete and sign the bottom of this letter.

This signed release **must** be submitted with your application to allow United Cerebral Palsy Association of Greater Suffolk to proceed with preparing you to be fingerprinted. You will be contacted, given an appointment to come to United Cerebral Palsy Association of Greater Suffolk, Hauppauge and provided with additional documents at that time.

I hereby give permission for _____, to have United Cerebral Palsy Association of Greater Suffolk, Inc. proceed with the finger printing process.

Signature of Parent/Guardian

Date