United Cerebral Palsy Association of San Diego County
Volunteer/Intern Information

All information will be kept confidential

_____
Date

_____ _____ _____
Last Name First Name Middle Initial

_____
Email Address

_____
Mailing Address (Number, Street, City and Zip Code)

_____ _____
Home Phone Cell Phone

_____
Emergency Contact – Name, Phone # and relationship

Do you require any special accommodations to assist your volunteer work?
_____Yes _____No

If yes, what? _____.

Do you have any past or pertinent health issues that would be necessary for emergency personnel to have knowledge of? If yes, please list:

_____
_____
_____.

Do you hold any of the following Certifications?
(Not a Required)

Current CPR?	_____Yes	_____ No
First Aid?	_____ Yes	_____ No
WSI?	_____ Yes	_____ No
Lifeguarding	_____ Yes	_____ No

Other certifications/ trainings that may be helpful in this position:
_____
_____.

Please list any education, paid or volunteer work experience, skills, hobbies, or interests, which might be helpful in your volunteer work.

_____
_____
_____
_____
_____.

Have you had any experience working with individuals with disabilities?
_____
_____
_____
_____.

Why do you wish to volunteer or intern in this program?
_____
_____
_____.

Note: A Criminal Record Clearance is required to volunteer in some UCPA programs. UCPA will cover the cost of these clearances.
Please indicate any other language or sign language spoken fluently:

Spoken: _____ Signed: _____

Please List two references (Name, Address and Phone Number)
_____
_____
_____
_____.

Liability and Consent Waivers

Photo, Video and Confidentiality

1. I the undersigned, hereby give to United Cerebral Palsy Association of San Diego County ("UCPA"), 8525 Gibbs Drive, Suite 209, San Diego, CA 92123, it's nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation or damages by reason thereof; (A) to take photographs, video and/or audio, of me and including the recording my voice; (B) to use, publish or republish the same furtherance of UCPA's work with or without identification of me by name; (C) to use my name and information referring to me in conjunction therewith if UCPA so desires; and (D) in furtherance of UCPA's work, to release such photographs, video and audio recordings to any news media, website, social media or other organization to use, publish or republish the same with or without identification of me by name, and to use my name and information referring in conjunction wherewith if UCPA so desires.

2. I understand that the above information is voluntarily supplied. The information may be used only for UCPA purposes. I understand as a volunteer or intern I will not be paid for my services. Any information received from my references will remain confidential.

3. Also, the Individuals served by UCPA are entitled to personal privacy rights. You, as a volunteer or intern may be given information about individuals on a need to know basis. This information will be given by the Program Coordinator and is not to be discussed with reference to name outside the agency under any circumstances. When discussing any program participants with a staff member, be sure to hold the conversation in private to protect confidentiality. Requests for information about program participants from other volunteers, collaborating agencies, visitors or event spectators should be referred to the UCPA Program Coordinator.

I, _____ understand this Confidentiality Policy as stated above. I promise to use information only for designated purposes, and will not disclose such information to any other person or agency unless specifically authorized by my UCPA Program Coordinator.

Signature: _____ Date: _____

General Abuse Statement for Volunteers

As a volunteer or intern for UCPA, which provides services to dependent youth and adults with disabilities, section 15630 of the Welfare and Institutions Code requires that if in any course of your volunteer or intern efforts you become aware of or observe injuries or witness statements from an individual under your care of supervision which indicates or substantiates that abuse has occurred, you are required to report that information to a UCPA staff members who is, in turn, required to report that information to a protective agency or law enforcement agency immediately. You, as a volunteer or intern, may be asked to assist in the preparation and sending of a written report within 36 hours of the observation as required by law.

I certify that I have read and understand the above statement and will comply with its provisions.

Signature: _____

Volunteer or Inter Liability Waiver

In consideration of and through my involvement as a volunteer or intern with United Cerebral Palsy Association of San Diego County, I acknowledge and agree that:

1. I risk bodily injury, including paralysis, dismemberment, death, as well as loss of or damage to property;

2. I knowingly and freely assume all such risk; and,

3. I, for myself, and on behalf of my heirs, assigns and next of kin, hereby release, hold harmless and promise not to sue the_____, United Cerebral Palsy Association of San Diego County (local program, or employees) with respect to any and all such injury, paralysis, dismemberment, death, and/or loss or damage (except that which is resultant of gross negligence and/or willful or wanton misconduct.)

Signature: _____ Date: _____

This is to certify that as Parent/Guardian of this participant, I do consent to his/her release of the United Cerebral Palsy Association of San Diego County from any and all liabilities incidental to his/her involvement as a participant for United Cerebral Palsy Association of San Diego County.

Parent/Guardian signature: _____ Date: _____

Volunteer/Intern Insurance

As a volunteer or intern at UCPA you will be covered under our Volunteer Accidental Medical Insurance when you are under the direction of and within the scope of duties assigned to you by the agency. For more information, contact your Program Coordinator or Human Resources at 858-571-7803. For student inter, please consult your school regarding insurance available.

Dismissal Policy

I understand at UCPA, my services can be terminated at any time at the sole discretion of UCPA, with or without notice and with or without cause.

Signature: _____ Date: _____

Revised: 2/2020