Leaps of Love – Volunteer Application

All fields are required to be filled out accurately. Incomplete applications will not be processed.

Please Print Name, Address and Telephone Numbers:

Last Name: _____

First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Cell Number: _____

Date of Birth: _____ Social Security Number: _____ - X - _____

E-Mail Address: _____

Spouse Name: _____

Spouse Home Number: _____ Cell Number: _____

Name of person to contact in case of an emergency:

Last Name: _____

First Name: _____

Relationship: _____

Daytime Telephone Number: _____ Cell Number: _____

Information about your education: Please fill in based on your current level of education and if you are completing volunteer hours for school/college credit.

I have completed: _____ High School _____ Some College _____College
*If applicable, please list the college that you are attending now: _____
If applicable, please denote what academic year you are in currently:
_____ Freshman _____ Sophomore _____ Junior _____ Senior
I have completed or am finishing Graduate School: _____
I need volunteer hours for school/college credit: _____ If yes, how many? _____

Information about your employment:

Employer: _____

Position: _____

Information about your health:

Leaps of Love
Embraces Families Affected By Childhood Cancer

Physician's Name: (please print)_____

Telephone Number: _____

Please list medications that you are currently taking: _____

_____

Please list any allergies and what you take for them: _____

_____

Is there any health reason that might limit your ability to volunteer? _____ Yes _____ No

If yes, please describe: _____

_____

Please check off the infectious illness you have had:

_____ Measles _____ Mumps _____Rubella _____ Chicken Pox _____ Diphtheria
_____ Polio _____ Tetanus _____Whooping Cough _____ COVID'19

Please check the infectious illnesses you have been immunized for:

_____ Measles _____ Mumps _____Rubella _____ Chicken Pox _____ Diphtheria

_____ Polio _____ Tetanus _____Whooping Cough _____ COVID'19

References:

Please print the COMPLETE mailing address of three people we may contact (excluding relatives and roommates) who have known you for more than two year. Local references preferred.

Name: _____ Relationship: _____

Address: _____City: _____ Zip: _____

Telephone Number: _____

Name: _____ Relationship: _____

Address: _____City: _____ Zip: _____

Telephone Number: _____

Name: _____ Relationship: _____

Address: _____City: _____ Zip: _____

Telephone Number: _____

Leaps of Love reserves the right to conduct state and federal background checks.

(*This report will be kept confidential*)

Have you ever been arrested for conducting or attempting to conduct a sexual offense? _____ Yes _____ No
If yes, please list the date(s) of the arrest(s) and any facts and circumstances surrounding the arrest(s). Being arrested does not automatically exclude you from consideration. If you meet the requirements, you will be able to explain the circumstances of your arrest. If you are subsequently arrested for conducting or attempting to conduct a sexual offense during the course of your volunteer services at LOL, you agree to notify us immediately. Failure to do so may result in termination of volunteer positions.

Date(s) and Arrest(s) facts and circumstances:

Have you ever been convicted, plead no contest, or plead guilty to a felony or misdemeanor? ____ Yes ____ No

Volunteer Privacy Information and Release Authorization:
Application Information

I certify that all information in this application is true and complete.

I understand that any false information or omission may disqualify me from further consideration for volunteer services and may result in my dismissal, if discovered, at a later date.

References

I understand that Leaps of Love requires information from me to evaluate my qualifications for volunteer services.

I authorize and release personal references, employers (past and present), and, if necessary, other applicable entities to answer questions in regards to volunteer work, employment, ability, character, medical and emotional background and, if applicable, driving history.

Background Investigation

I understand, in consideration of my application, a background investigation will be conducted.

I understand this investigation may include, but is not limited to, a criminal background check in the files of any Federal, state or local justice agency, driving history, performance of medical examinations, drug screenings or reference verification.

I authorize Leaps of Love and associated entities to conduct the background investigation and release LOL from responsibility for this investigation.

I understand the requested information is for the sole purpose of gathering accurate information for volunteer services of Leaps of Love.

I have read and understand the above and by my signature consent to these statements.

Applicant Signature **Date**

Return Application to: **Leaps of Love, Inc.**
1005 B Broadway
Highland, IL 62249
(618) 882-5399 Fax

Leaps of Love
Embraces Families Affected By Childhood Cancer

Leaps of Love

Confidentiality Acknowledgement & Agreement Form

Print Name: _____

During the course of your activity with Leaps of Love, you may have access to information which is confidential and may not be disclosed except as permitted or required by law. In order for Leaps of Love to properly care for their families and engage in successful planning, certain information must remain confidential. Improper disclosure of confidential information can cause irreparable damage to Leaps of Love. Confidential information includes, but is not limited to:

1. Medical and certain personal information about the family members.
2. Medical staff records and committee proceedings.
3. Reports, policies and procedures, marketing to financial information, and other information related to the business of services of Leaps of Love which has not previously been released.

If you have any questions at any time concerning confidentiality or disclosure of information, you should contact the Leaps of Love office at 618-410-7212.

By initialing each section and signing this Confidentiality Acknowledgement, you acknowledge and agree that:

_____ 1. I will only access family information for which I have a legitimate purpose for.

_____ 2. Medical information is confidential and my access is restricted to my legitimate medical need to know for caring of the family and its members.

_____ 3. I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of Leaps of Love.

_____ 4. I will only publish photos/videos of families that have already signed the Publicity Waiver through Leaps of Love.

_____ 5. Failure to comply with my confidentiality obligation may result in disciplinary action by Leaps of Love.

_____ 6. Impermissible disclosure of confidential information about a person may result in legal action being taken against me by or on behalf of that person.

_____ 7. My confidentiality obligation shall continue *indefinitely,* including at all times after my association with Leaps of Love.

I HAVE READ AND UNDERSTAND THIS CONFIDENITALITY AGREEMENT, HAVE HAD MY QUESTIONS FULLY ADDRESSES, AND HAVE RECEIVED A COPY FOR MY PERMANENT PERSONAL RECORD.

Volunteer Signature: _____

Print Name: _____ Date: _____