

**Volunteer Application Camp *WANNAGOAGAIN!***

**At time of Camp:**  
☐ Check Here if Under 18

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>
<b>Address Street</b>	<b>City</b>	<b>State Zip Code</b>
<b>Email Address</b>	<b>Cell Phone</b>	<b>Social Security Number</b>
<p><b>Check position you are applying for:</b></p> <p><input type="checkbox"/> Volunteer</p> <p><input type="checkbox"/> Professional Volunteer Experience</p>		

<p><b>I am available to volunteer for the following schedule:</b></p> <p><input type="checkbox"/> Camp Setup (Sunday prior to start of camp)   <input type="checkbox"/> Week One   <input type="checkbox"/> Week Two   <input type="checkbox"/> Both Weeks</p> <p><b>The best way to contact me is :</b> _____</p> <p><b>In case of emergency please contact:</b></p> <p><b>Name:</b> _____ <b>Relationship:</b> _____ <b>Phone Number:</b> _____</p>
<p><b>How Did You Hear About Us? (check one)</b></p> <p>Advertisement <input type="checkbox"/>   Job/Career Fair <input type="checkbox"/>   Internet <input type="checkbox"/></p> <p>Employment Agency <input type="checkbox"/>   Walk-In <input type="checkbox"/>   Other: _____</p>
<p><b>For Office Use Only:</b></p> <p><input type="checkbox"/> Applicant has previous camp experience and is approved for packet</p> <p><input type="checkbox"/> This applicant will be interviewed</p> <p><input type="checkbox"/> Applicant has received paperwork packet</p> <p><b>Assigned to:</b> _____ <b>Completed by:</b> _____</p>

**\*\*\*\*\* REFERENCES \*\*\*\*\***

**REFERENCES MUST BE CURRENT AND/OR FORMER SUPERVISORS. DO NOT LIST THE NAMES OF ANY FRIENDS OR RELATIVES.**

<b>1. Name:</b>	<b>Relationship:</b>
<b>Address:</b>	<b>Phone:</b>
<b>2. Name:</b>	<b>Relationship:</b>
<b>Address:</b>	<b>Phone:</b>
<b>3. Name:</b>	<b>Relationship:</b>
<b>Address:</b>	<b>Phone:</b>

**EMPLOYMENT/EXPERIENCE**

**Begin with your present or last job. Include any job related military service assignments and volunteer activities. Gateway will contact the employers listed below as part of the agency's background investigation of all prospective employees.**

<b>Employer</b>	<b>Dates Employed</b>		<b>Job Duties/Responsibilities</b>
	<b>From</b>	<b>To</b>	
<b>Address</b>			
<b>Phone Number(s)</b>	<b>Hourly Rate Salary</b>		
<b>Job Title</b>			
<b>Supervisor</b>	<b>Reason for Leaving</b>		

<b>Employer</b>	<b>Dates Employed</b>		<b>Job Duties/Responsibilities</b>
	<b>From</b>	<b>To</b>	
<b>Address</b>			
<b>Phone Number(s)</b>	<b>Hourly Rate Salary</b>		
<b>Job Title</b>			
<b>Supervisor</b>	<b>Reason for Leaving</b>		

<b>Employer</b>	<b>Dates Employed</b>		<b>Job Duties/Responsibilities</b>
	<b>From</b>	<b>To</b>	
<b>Address</b>			
<b>Phone Number(s)</b>	<b>Hourly Rate Salary</b>		
<b>Job Title</b>			

**EDUCATION**

	Name and Address of School	Course of Study	Years Completed	Diploma/Degree
High School				
College				
Graduate				
Other				

**INDICATE ANY LANGUAGE YOU CAN SPEAK, READ AND/OR WRITE, INCLUDING ENGLISH**

	FLUENT	GOOD	FAIR
<b>SPEAK</b>			
<b>READ</b>			
<b>WRITE</b>			

**DESCRIBE ANY SPECIALIZED TRAINING, APPRENTICESHIP, SKILLS, EXTRA CURRICULAR ACTIVITIES, AND VOLUNTEER SERVICES WHICH YOU BELIEVE ENHANCE/RELATE TO THE ABILITIES NECESSARY FOR THE POSITION BEING SOUGHT.**


**LIST PROFESSIONAL, TRADE, BUSINESS, OR CIVIC ACTIVITIES AND OFFICES HELD WHICH YOU BELIEVE ENHANCE/RELATE TO THE ABILITIES NECESSARY FOR THE POSITION BEING SOUGHT.**


All offers of employment are **conditional** until information on this form has been checked. Gateway Healthcare or its affiliates may revoke any offer of employment if it finds that the applicant's responses are false, misleading or incomplete in any way.

Offers of employment with Gateway Healthcare or its affiliates are made solely by Gateway Healthcare Human Resource representatives. Gateway Healthcare or its affiliates are subject to numerous legal and ethical requirements related to the health and safety of its employees and consumers. As one mechanism to assure compliance with some of these requirements, all applicants are required to complete the following. **A "false" to any of the below does not necessarily disqualify a person from employment.**

1. I am not included on Rhode Island's child abuse and neglect tracking system (CANTS). True ☐ False ☐

2. I do not have, nor have I ever had, a consumer or business relationship with Gateway or its affiliates. True ☐ False ☐

\*\*\*If false, with what entity is/was your relationship? \_\_\_\_\_

3. To my knowledge, no one in my family ("family" shall be defined as spouse, partner, brother, sister, or parent) or an individual with whom I have a close personal relationship has or has had a business or consumer ("consumer" shall be defined as individuals who are receiving or have received clinical services) relationship with a Gateway or Affiliate Provider. True ☐ False ☐

4. I have not been sanctioned/penalized by any agency of the federal government. True ☐ False ☐

5. If I am a licensed professional, my license is current and I am in good standing with my professional organization in Rhode Island. True ☐ False ☐

6. If you are under 16 Years of age, can you provide required proof of Your Eligibility to work? ☐ Not Applicable ☐ YES ☐ NO

7. Are you a user of tobacco products? ☐ YES ☐ NO

8. Are you authorized to work for any company in the United States of America? ☐ YES ☐ NO

**Proof of citizenship or immigration status will be required upon employment**

**We consider applicants for all positions without regard to race, color, religion, creed, or gender, national origin, age, disability, marital status or veteran's status, sexual orientation, gender expression or any other legally protected status.**

**We Are An Equal Opportunity Employer**

- I certify that the answers given herein are true and complete to the best of my knowledge.
- I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.
- I ☐ **Authorize** ☐ **Do Not Authorize** GHI to contact the employers listed herein, and to request and obtain any such information it deems relevant to the employment decision.
- I hereby understand and acknowledge that any employment with Gateway Healthcare, Inc. or its Affiliates is of an "at will" nature, which means that I may resign at any time and that Gateway Healthcare, Inc. or its Affiliates may discharge me at any time with or without cause. I also understand that no policy, manual or other document, conduct, or representation by or on behalf of Gateway Healthcare, Inc. or its Affiliates can change the "at will" nature of my employment unless and until an authorized executive of Gateway Healthcare, Inc. expressly states in writing that the nature of my employment is changing to other than "at will" and the executive signs it in his/her official capacity.
- If I am over 18, I understand that a BCI background check will be conducted. I understand that if I am applying for a position within a children's/substance abuse program, a CANTS/BCI background check will be conducted. I understand that employment is contingent on the results of a CANTS and/or BCI background check.
- In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand also that I am required to abide by all rules and regulations of the Employer.

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By my signature below, I certify that the above information is accurate. I understand that any offer of employment will be conditional until the above information has been confirmed. If Gateway Healthcare, Inc. or its Affiliates finds that any of the above information is false, misleading or incomplete, it may be revoked, even if such determination is made after I start work.

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**Applicant Signature**

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**Date**



Employee and Occupational  
Health Services

## Lifespan

Dear Student Intern/Volunteer Candidate:

**An Immunization Record Review in Employee and Occupational Health Services (EOHS) is required before you can attend orientation at a Lifespan site. The following immunization records must be complete before you can start your placement:**

➤ **MAKE EVERY EFFORT TO BRING THESE RECORDS TO YOUR EOHS SCREENING:**

- **MMR**: 2 Measles, 2 Mumps and 1 Rubella containing vaccines or blood tests showing immunity.
- **Varicella** (Chicken Pox): Provider diagnosis of past disease, or 2 Varicella vaccines, or positive blood test showing immunity.
- **Tdap**: 1 vaccine required.
- **Hepatitis B**: Bring proof of your vaccinations and any blood tests showing immunity.
- **Tuberculosis**: TB skin test test with actual millimeter reading-done within the previous 6 months- or blood assay for TB (BAMT). Those with positive TB skin tests need results in millimeters and a chest x-ray after positive result.
- **Influenza**: Date of influenza vaccine or medical exemption by 10/31.

➤ **WHERE CAN IMMUNIZATION RECORDS BE FOUND?**

- Call your provider and ask them to complete and sign the immunization form (attached).
- Contact your former employer, school, college, health clinic, or military service for these records.

➤ **WHERE SHOULD I SEND/BRING MY IMMUNIZATION RECORDS?**

Bring a copy of your immunization records to your EOHS appointment, or

Fax your completed immunization form –that identifies your name and your volunteer status--to Employee and Occupational Health Services before your appointment at the fax numbers for your site:

Bradley Hospital

401-432-1513

- Completed immunization records are important to avoid delays in starting your new job.  
Thank you.

*The Employee and Occupational Health Services Staff*



## Lifespan

### VOLUNTEER IMMUNIZATION RECORD

NAME \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

#### All Candidates Require:

**Tuberculosis:**  
PPD Plant date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Read date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_mm  
  
Two-step date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Read Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_mm  
  
Or  
Blood assay for Mycobacterium Tuberculosis (BAMT)  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_

\*Anyone with a Positive PPD needs the date and result documented in millimeters. Anyone with a positive PPD or BAMT needs documentation of chemotherapy or prophylaxis or a Chest X-ray on after the positive result.  
Positive PPD Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_mm

Chest X-ray Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_

**Varicella (Chicken Pox):**  
Healthcare Provider Diagnosis of Varicella Disease: Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
or  
Varicella vaccine: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ and #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
or  
Titer: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_

**TETANUS , Diphtheria and Pertussis (Tdap)**  
\*Tdap date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Influenza vaccine:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Medical Exemption \_\_\_\_/\_\_\_\_/\_\_\_\_

**MMR**  
2 Measles, 2 Mumps and 1 Rubella containing vaccines  
or positive titers  
  
Rubeola (Measles):  
Titer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_  
or  
Vaccine #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Mumps:**  
Titer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_  
or  
Vaccine #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Rubella (German Measles):**  
Titer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_  
or  
Vaccine #1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
or  
**MMR:**  
Vaccine #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

Optional except for those employees exposed to Blood/Body Fluids

#### Hepatitis B:

#1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
#2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
#3 \_\_\_\_/\_\_\_\_/\_\_\_\_ or Signed Declination Y / N  
HbsAb: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_

Provider  
Signature \_\_\_\_\_

Date \_\_\_\_\_



Name: \_\_\_\_\_

(Print or Type)

Maiden Name: \_\_\_\_\_

D/O/B: \_\_\_\_\_

Please direct all correspondence to: The Autism Project, 1516 Atwood Avenue, Johnston, RI 02919

**DISCLAIMER**

I \_\_\_\_\_ hereby direct and authorize the Bureau of Criminal Identification of the Department of Attorney General for the State of Rhode Island to make available to \_\_\_\_\_ any criminal record that the Bureau of Criminal Identification has on file in reference to me.

I hereby waive and release any and all manner of actions, cause of actions, and demands of every kind, nature and description, arising from any release of criminal records and requests therefrom, whatsoever against the State of Rhode Island, Bureau of Criminal Identification, the Attorney General, and employees of the Attorney General's Office in both law and equity which I may now have or in the future may have.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sworn to before me in the City of \_\_\_\_\_, State of \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expires

**NOTE: Copy of photo identification with date of birth must accompany this**

**Disclaimer (front AND back).**

**\*\*As of July 23, 2018, ALL in-person transactions can only be completed at our new customer service building located at 4 Howard Avenue in Cranston.**

**All mail transactions shall continue to be mailed to:  
Attorney General Julius C. Michaelson Customer Service Center  
4 Howard Avenue Cranston, RI 02920**



STATE OF RHODE ISLAND  
Department of Children, Youth and Families  
101 Friendship Street  
Providence, RI 02903

**DCYF Clearance Request/Results (Facility)**

\$10.00 fee is required, (agency check, cashier check or money order payable to: "**General Treasurer State of Rhode Island**" – a personal check or cash is not accepted. Requests submitted without payment **will not** be processed.)

Facility Name: **The Autism Project**

☐ Please indicate if subsequent

Facility mailing address: **1516 Atwood Avenue, Johnston, RI 02919**

Facility E-mail address: **jmoran1@lifespan.org**

Facility Phone #: **401-785-2666**

Please indicate: ☐ Prospective Childcare operator or employee ☐ Foster Care provider  
☐ Non-DCYF Adoption ☐ Employment ☐ Community Agency Volunteers who have  
supervisory authority over children without the presence of others ☐ Volunteer in a daycare  
setting ☐ Child Care and Community Agency Volunteers who **do not** have supervisory  
authority over children without the presence of others

**INFORMATION RELEASE**

I hereby authorize the Department of Children, Youth and Families to release to, The Autism Project, information obtained as a result of their check of the Department's Indicated Child Abuse/Neglect records. I understand that this records check is required by R.I.G.L. 40-13.2-3.1 and that information obtained as a result of this check may be used by the Department or the facility in determining my suitability for employment in a Child Care facility. This authorization will expire upon receipt by the facility of the Clearance Check Results Ninety (90) days after the date of this authorization appearing below. Any information released and/or received as a result of this consent shall not be further relayed in any way to any person or organization outside of the Department without additional consent except as provided by statute.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Maiden

\_\_\_\_\_  
Address

\_\_\_\_\_  
# & Street

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**BACKGROUND CHECK RESULTS**

**RICHIST:** ☐ No Prior Contact

Case ID or Person ID: \_\_\_\_\_ Case Name: \_\_\_\_\_ States: ☐ Active ☐ Closed

\_\_\_\_\_  
Investigation #

\_\_\_\_\_  
Level

\_\_\_\_\_  
Status

\_\_\_\_\_  
Name

\_\_\_\_\_  
Involvement

\_\_\_\_\_  
Allegations

**MASTERFILE:**(Prior to 1984)

☐ No prior Involvement

**STATE OF RHODE ISLAND  
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES**

**Employment History Affidavit**

Please list employment history for the past three (3) years in chronological order. If you have not been employed for any period of time during the past three (3) years, please indicate below the dates of unemployment.

Employer			Address
From	To	Occupation	Supervisor
Employer			Address
From	To	Occupation	Supervisor
Employer			Address
From	To	Occupation	Supervisor
Employer			Address
From	To	Occupation	Supervisor

I, the undersigned, attest that the information contained in this affidavit is complete and accurate and understand that any false representation may be cause for denial or termination of employment or denial of licensure or certification.

Applicant	Date
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\* Subscribed and sworn to before me \_\_\_\_\_  
\_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Notary Public

**STATE OF RHODE ISLAND  
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES**

**Criminal History Affidavit**

Applicant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Have you ever been arrested for or convicted of any offense set forth in DCYF Policy 900.0040, Criminal Records Checks ☐ Yes ☐ No  
Addendum – Disqualifying Information?

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, attest that the information contained in this affidavit is complete and accurate and understand that any false representation may be cause for denial or termination of employment or denial or revocation of licensure or certification. I further agree to apply to the Bureau of Criminal Identification of the State or local Police for a nationwide criminal records check prior to beginning employment. I also understand the Department and/or employer will receive information relating to the results of the criminal records check. I understand if there is a question as to the conviction information, I am entitled to appeal to the FBI. If there is a question as to my denial or termination of employment or denial or revocation of licensure or certification due to the results of the criminal records check, I am entitled to appeal to the DCYF Administrative Hearing Officer.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn before me on this date \_\_\_\_\_

\_\_\_\_\_  
Notary Public



# Lifespan

*Delivering health with care.®*

## Child Safe Zone

In accordance with R.I. General Laws Chapter 11-37.3, I certify that I am not currently registered, or required by law to be registered, as a sex offender in Rhode Island or in any other jurisdiction, as a result of being convicted of a sexual offense against a minor. If I become a Lifespan employee and during my employment by any Lifespan affiliate that is intended primarily for providing services to minors, I am convicted of a relevant offense and am required by law to be registered as a sex offender in Rhode Island or in any other jurisdiction, I will immediately notify the Lifespan affiliate's Human Resources Department of this change. If this occurs, or if I fail to so notify the Human Resources Department of such a change in my status, I understand that my employment may be immediately terminated.

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Signature

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Date



# Lifespan

*Delivering health with care®*

## **Confidentiality Agreement for Guests of Lifespan**

Patient care is of primary concern for all employees of Lifespan and protecting patients' rights to privacy is one of our most important responsibilities. Patient information from any source, in any form, is strictly confidential.

I, the undersigned, agree to protect the privacy and patient confidentiality of any patient with whom I may have access, or that I may see or overhear, during my visit to Lifespan. This includes all information related to patients, including but not limited to patient names and other personal information, medical records, conversations or financial information. I will not show, tell, copy, give, sell or review any confidential information with anyone.

By signing this form, I agree that I have read, understand and will comply with this agreement.

Print Name: \_\_\_\_\_

Program/Service \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_