Please do not fax to the State! 1 H H G V W R olunteer Services Office W X U Q H G W R

AUTHORIZATION TO
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF49Ah2LONG TERM CARE RESIDENTS P49AhROTECTION
FO THELEASO ADULT ABUSISY INFOMATIO

Employer: 1 H P R X U V & K L O G U H Q V +

Addres **1600 Rockland Road**
Wilmington, 19803

DELAWARE CHILD PROTECTION REGISTRY CONSENT FORM

Web Portal

Request must be within 90 days of signature date in order to be processed

PART I - APPLICANT INFORMATION

Name(Last*, First*, Middle): _____

Other Name(s) used/Alias: _____

Social Security #: _____

Date of Birth(mm/dd/yyyy)*: _____

Gender*: _____

Race: _____

Ethnicity: (Hispanic/Non-Hispanic) _____

Address (Street, City, State, Zip): _____

Are you on the Delaware Child Protection Registry for any substantiated cases of child abuse/neglect? ☒ No ☐ Yes

If yes, explain:

n Nemours Children's Health, Delaware Valley - Volunteer Services

☐

☐

Requesting Agency 1 – Agency Name*

Requesting Agency 2 – Agency Name*

Requesting Agency 3 – Agency Name*

Requesting Agency 4 – Agency Name*

Requesting Agency 5 – Agency Name*

* Mandatory(Agency Name is Mandatory)

NEMOURS VOLUNTEER SERVICES CODE OF CONDUCT, COMMITMENT & QUALITY

DEPENDABILITY AND QUALITY OF WORK

- I will be punctual and conscientiouRVICES c49 715.92 Tmmn b band

NEMOURS VOLUNTEER SERVICES
CODE OF CONDUCT, COMMITMENT & QUALITY 5 .3 32994 (t)8 (o)24 (

SERVICE EXCELLENCE

ƒ I will exhibit a pleasant attitude and utilize AIDET principles for Service Excellence.

A	ACKNOWLEDGE Goal: Establish trust by demonstrating empathy. x I will make eye contact, smile, and give a cheerful comment/greeting to everyone I meet. To be courteous, I will stop what I am doing so others will know that they are important. x I will conduct myself appropriately with dignity and courtesy. x I will work, walk, and talk quietly so I will not disturb others.
I	INTRODUCE Goal: Reduce anxiety by sharing with the patients the skill set and experience of those that will be caring for them. x , Z L O O H [W H Q G D Z H O F R P H D Q G L Q W U R G X F H P \ V H O volunteer here at Nemours for ___days/months/years.

Authorization to Release Photo/Video/Audio for Publication

Adult, Non-Associate

1. I, (print name)_____, authorize Nemours Children's Health to USE AND/OR DISCLOSE the above-named person's information and story with media outlets, social media channels and networks, advertising, websites, public marketing, promotional materials, training and/or presentation and other similar venues.

2. The following people and/or media organizations will have access:
   Nemours Social Media Outlets and Volunteer Recognition Wall

3. This authorization will expire:
   On a specific date (if checked, enter the date) _____
   After the completion of the following event/service/project _____
   ☑ 10 years from date this form is signed

I understand that:

- I can change my mind and revoke this authorization, in writing, at any time, by sending a written revocation
  Parkway North, Jacksonville, Florida 32256 or call 800.472.6610.
- Information used or disclosed may be redistributed by the recipient and may no longer be protected by Federal or state confidentiality law.
  – It is common that disclosures for broadcast or publication will include posting the materials onto web, social media or similar sites. Once this occurs your information will be publicly available and freely distributed.

Promote Volunteer Services	Judy Lieberman
Varies	Volunteer Services
☐	Delaware Valley

Immunization Record
Volunteers

Please provide a copy of your immunization record by either method below:

- Have a Licensed Provider complete and sign this form OR
- Attach a copy of your immunization record to this form in lieu of a Licensed Provider [illegible]

Name: _____ Date of Birth: _____

[illegible] Address: _____ Attach a c