TOUCH BASE: CENTER FOR THE DEAFBLIND

For people with deafblindness, and those who support them, to build connections with the community, promote self-respect, improve communication and daily living skills, while creating moments of joy.

VOLUNTEER REGISTRATION PACKAGE

Dear volunteer/visitor,

Welcome to Touch Base: Center for the Deafblind.

In an effort to provide the best possible service to our clients and volunteers, we would like you to complete some paperwork. The forms include the following:

1. Volunteer Contact Form
2. Volunteer Questionnaire
3. Background Check (2 pages)
4. Media Release Form
5. Confidentiality Agreement

We also request you to read our Policies and Procedures for Volunteers and Visitors Handbook and sign below that you understand and agree with our policies.

Thank you.

Name: _____

Signature: _____

Date: _____

15 AZALEA TRAIL LANE, BELLAIRE, TEXAS 77401, PHONE: 832-877-3333, CONTACT@TOUCHBASECENTER.ORG

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VOLUNTEER CONTACT FORM

NAME: _____ DOB: _____

ADDRESS:_____

PHONE NUMBER: _____

CELL NUMBER: _____

EMAIL ADDRESS: _____

Would you like to be added to Touch Base's listserv to receive updates: Y / N

EMERGENCY CONTACT #1 NAME/NUMBER:

_____

EMERGENCY CONTACT #2 NAME/NUMBER:

_____

PREFERRED HOSPITAL FOR EMERGENCY:_____

REFERENCES:

1. NAME:_____ RELATION: _____

NUMBER: _____ EMAIL: _____

2. NAME:_____ RELATION: _____

NUMBER: _____ EMAIL: _____

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VOLUNTEER QUESTIONNAIRE

NAME: _____

We are delighted that you want to volunteer with us. Why are you interested in volunteering with Touch Base?

_____

_____

_____

_____

Touch Base would like to teach/help you in any way that we can. Do you have experience working with deafblind individuals? What skills/certifications/interests do you have? (i.e. sign language, symbols, O&M...)

_____

_____

_____

_____

Other information you would like us to know about you? (i.e. accommodations, special requests, areas of interest...)

_____

_____

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VOLUNTEER BACKGROUND CHECK

NAME: _____
(First) (Middle) (Last)

Date of Birth (MM/DD/YYYY): _____

Former Name(s) and Dates Used:

_____

Current Address Since:

_____
(Mo/Yr) (Street)

_____
(City) (Zip/State)

Previous Address:

_____
(Mo/Yr - Mo/Yr) (Street)

_____
(City) (Zip/State)

Previous Address:

_____
(Mo/Yr - Mo/Yr) (Street)

_____
(City) (Zip/State)

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

Notification

The position for which I am being considered requires me to consent to a criminal background check as a condition of involvement. This check includes the following: Criminal history reference searches for felony and misdemeanor convictions at the county and federal levels of every jurisdiction where I currently reside or where I have resided during the past 7 years; and sex offender registry searches at the county and federal levels in every jurisdiction where I currently reside or where I have resided.

Authorization

I hereby authorize Touch Base: Center for the Deafblind to conduct the criminal background check described above. In connection with this, I also authorize the use of law enforcement agencies and/or private background check organizations to assist Touch Base: Center for the Deafblind in collecting this information. Texas Department of Public Safety has been secured to assist Touch Base: Center for the Deafblind in collecting and verifying information.

I also am aware that records of arrests on pending charges and/or convictions are not an absolute bar to involvement. Such information will be used to determine whether the results of the background check reasonably bear on my trustworthiness or my ability to perform my duties in a manner which is safe for Touch Base: Center for the Deafblind clients, employees, and other members.

Name: _____ Date: _____

Signature: _____

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MEDIA RELEASE FORM

I, _____ (name), the guardian of _____ (client name) give my permission to Touch Base: Center for the Deafblind to use his/her photos and videos publicly.

I understand that the images may be used in print publications, online publications, presentations, websites and social media such as Facebook.

I also understand that no royalty fee or other compensation shall become available to me by reason of such use.

I am aware that I can revoke this permission at any time, by notifying Touch Base staff. Unless revoked, this consent will remain in effect indefinitely.

Client's name: _____

Guardian's name: _____

Guardian's signature: _____

Date: _____

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CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES

Direction for Use:

This form is to be completed by Non-Agency employees who, through the routine performance of services for the Agency, might view or have opportunity to gain access to patient information.

I have been made aware that confidential patient records are maintained on the premises which I have access to. Due to legalities surrounding patient confidentiality, I understand that I am not permitted access to these documents. I further agree that all documentation found on the premises shall remain as found and shall not be removed from the premises.

By my signature below, I acknowledge that I have read, understand and comply with all the above information. I agree to comply with and be bound by the policy listed above.

Date	**Signature**	**Company/Firm**

Date	**Signature of Administrator**