North Star Council on Aging, Inc.
Fairbanks Senior Center
1424 Moore Street, Fairbanks, AK 99701
(907) 452-1735 Phone | (907) 451-9974 Fax

Volunteer & Background Check Application

**Asterisks mark required fields. Background Checks can not be processed without complete information.*

Personal Information

*Full Legal Name: ______________________________ / / ______
**Last* **First* *M.I.* *Date of Birth (mm/dd/yyyy)

*Permanent/ Physical Address: ______________________________
**Physical Street Address* **Apartment/Unit #*
____
**City* **State* **ZIP Code*

Mailing Address (if different than Permanent/ Physical Address): ______________________________
**Mailing Address* **Apartment/Unit #*
____
**City* **State* **ZIP Code*

*Primary Phone: ( ) ______________ Secondary Phone: ( ) ______________
This is a cell phone

*Applicant's Email Address: ______________ *Driver's License Number: ______________

*SSN (or ITN) : ______________ *Driver's License State: ______________
☐ This is an ITN

Demographic Information

*Race: (Asian, Black, White Native American, or Unknown) ______________
*Gender: (Male, Female, Unknown, Other) ______________

*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) ______________
*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) ______________

*Height: ____ **FT** ____ **IN** *Weight: ____ **Lbs.** US Citizen(Y/N): ____ *Place of Birth *(Country/State): ______________

Volunteer Availability

Volunteer Position Desired or Applying for: ______________________________

Available Start Date: ______________ Total Hours Available Per Week: ______________

Please list the days and times you are available to volunteer		Monday	Tuesday	Wednesday	Thursday	Friday
	From (time)					
	To (time)					

Emergency Contact Information

Name: ______________ Relationship: ______________ Primary Phone:( ) ______________

____
Physical Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Background Check Application for: First Name: __________________________ Last Name: _______________________ DOB: ____________

Volunteer Prior History

Prior Addresses in the last 10 years: Please list the addresses in which you have lived for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time.

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Full Address: ____ Month/Year From: ______________ To: ______________

Prior Names Used in the last 7 years: Please list all names (alias(es), maiden name, etc.) to which you have been known for the last 7 years.

Full Name: ____ Month/Year From: ______________ To: ______________

Full Name: ____ Month/Year From: ______________ To: ______________

Authorization to Obtain Volunteer Background Report

Disclosure Regarding Volunteer Background Report

North Star Council on Aging may obtain from Sterling Volunteers, 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860. www.sterlingvolunteers.com, a consumer report and/or an investigative consumer report (“REPORT”) that contains background information about you in connection with volunteerism. Sterling Volunteers may obtain further reports throughout your volunteerism so as to update your report without providing further disclosure or obtaining additional consent.

The REPORT may contain information about your character, general reputation, personal characteristics and mode of living. The REPORT may include, but is not limited to, credit reports and credit history information; criminal and other public records and history; public court records; motor vehicle and driving records; and Social Security verification and address history, subject to any limitations imposed by applicable federal and state law. This information may be obtained from public record and private sources, including credit bureaus, government agencies and judicial records, and other sources.

If an investigative consumer REPORT is obtained, in addition to the description above, the nature and scope of any such REPORT will be for personal references.

Initial Below:

I agree that a facsimile (fax), electronic or photographic copy of this Authorization shall be as valid as the original.

I acknowledge receipt of a copy of the Consumer Financial Protection Bureau’s “A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT.”

I, ______________________________, have read the Disclosure Regarding Volunteer Background Report (above) and this Authorization to Obtain Volunteer Background Report. By my signature below, I hereby consent to the preparation by Sterling Volunteers, a consumer reporting agency located at 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860, www.sterlingvolunteers.com, of background reports regarding me and the release of such reports to the COMPANY and its designated representatives, to assist the COMPANY in making a volunteer decision involving me at any time after receipt of this authorization and throughout my volunteerism, to the extent permitted by law. To this end, I hereby authorize, without reservation, any state or federal law enforcement agency or court, educational institution, motor vehicle record agency, credit bureau or other information service bureau or data repository, to furnish any and all information regarding me to Sterling Volunteers and/or the COMPANY itself, and authorize Sterling Volunteers to provide such information to the COMPANY.

____ ______________________

Applicant Signature Date

STATE OF ALASKA
DIVISION OF MOTOR VEHICLES
COMPANY RELEASE FOR MULTIPLE DRIVING RECORDS

Company or Business Name (Please Print)	Telephone Number

The undersigned authorizes the DMV to release their driving record to the above business or company:

*ALASKA DRIVER LICENSE NUMBER	*PRINTED NAME	*CIRCLE RECORD TYPE**			*SIGNATURE	*DATE (Valid for 90 days)
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		
		Full Individual	Insurance	CDL Employment		

**** Driving Record Types (*What's the difference?*)**

Full Individual Record:
Shows current driving record status, and includes all convictions, license actions, and at-fault accidents on record; includes full medical certification details for commercial (CDL) drivers.

Insurance Record:
Shows current driving record status, and 3 or 5 year history of convictions, license actions, and at-fault accidents required for vehicle insurance purposes; excludes any medical certification information on record. (3 or 5 year reporting requirement is based on the type of conviction or action.)

CDL Employment Record:
Shows current driving record status; full medical certification information; and conviction, license action, and at-fault accident information as required by DOT regulations for commercial (CDL) drivers. CDL drivers must select this type of record when used for CDL employment purposes.

Submit requests to DMV Research:
1300 W. Benson Blvd., Suite 410
Anchorage, AK 99503
Phone: 907-269-3754
Fax: 907-269-5202
Email: doa.dmv.research@alaska.gov

I want the driving records to be sent via: ☐ Email ☐ Fax ☐ Mail (Select only one)

Mailing Address	Fax Number
City / State / Zip	Email
Make checks payable to DMV, or State of Alaska, OR complete the following to make payment by credit card.	
Card Number (Visa or MasterCard)	Exp. Date
Name as shown on card	Security Code (3 digit code on back of card)
I understand that the credit card shown above will be charged $10 for each record type selected.	
Authorized Cardholder Signature	Date (Valid for 90 days)

DMV USE ONLY			
☐ I have verified ID for in-person request Expiration Date:	BATCH	AMVC ID / OFFICE	TOTAL FEES: _______ CA CC CK

North Star Council on Aging
Confidentiality Agreement

Respecting the privacy of our clients, donors, members, employees, and volunteers is a basic value of North Star Council on Aging (NSCoA). Employees, volunteers and board members of NSCoA may be exposed to information which is confidential and /or privileged and proprietary in nature.

NSCoA strives to keep personal information confidential, regardless whether it is company (employee / board), or service (client / consumer) information. As a business associate with organizations with HIPPA compliance in force, information shall be held in the strictest of confidence, and be treated with the sensitivity of HIPPA guidelines to fulfill Memorandum of Agreement with partner organizations.

It is the policy of NSCoA that all personal and financial information must be kept confidential and should not be disclosed or discussed with anyone without permission or authorization from the Executive Director. Care shall also be taken to ensure that unauthorized individuals do not overhear any discussion of confidential information and that documents containing confidential information are not left in the open or inadvertently shared.

Employees, volunteers, and board members, are expected to return materials containing privileged or confidential information at the time of separation from employment or expiration of service.

Unauthorized disclosure of confidential or privileged information is a serious violation of this policy and will subject the person(s) who made the unauthorized disclosure to appropriate discipline, including removal/dismissal.

By signing this agreement, you as a NSCoA employee, volunteer or board member, hereby agree not to use, publish, or disclose such information during or after your employment or volunteer service.. You also agree that you will preserve the restricted nature of this information except to the extent that it becomes publicly available, or otherwise lawfully obtained outside the scope of this agreement from third parties.

Aditionally, as an employee, volunteer, or board member, you realize that you have an obligation to disclose and eliminate, if necessary, any potential or actual conflict of interest.

I have read NSCoA's confidentiality policy as presented above. I agree to abide by the requirements of the policy and inform my supervisor immediately if I believe any violation (unintentional or otherwise) of the policy has occurred. I understand that violation of this policy will lead to disciplinary action, up to and including, termination of my service with NSCoA.

Signature ____

Print Name ______________________________________

Date __________________________

Notice of Privacy Practices

This document describes how North Star Council on Aging may use and disclose your protected health information to carry out services, permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, or business associates, and that relates to your past, present or future physical or mental health or condition

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with the Notice of Privacy Practices and applicable law.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, business associates, and our office staff who are involved in your care and treatment for the purpose of providing care services to you. Your protected health information may also be used and disclosed to pay for your services and to support the operation of your care.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

- You have the right to inspect and copy your protected health information
- You have the right to request a restriction or amend your protected health information
- You have the right to request a restriction of your protected health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information and the right to obtain a paper copy of this notice from us

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Executive Director of your complaint. We will not retaliate against you for filing a complaint**.**

You may contact our Executive Director at 907-452-1735 for further information about the complaint process. This notice was published and becomes effective on August 23,2012**.**

CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy.

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Signature

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Date