Autism Collaborative Center
Service ■ Education ■ Research ■ Community
Eastern Michigan University

Student/Volunteer Application & Release Form

Full Name: **Date of Birth:** **Today's Date:**

Street Address:

City: **State:** **Zip:**

Email:

Telephone: *Cell* *Home*

Emergency Contact Name:

Relationship: **Emergency Contact Phone:**

Are you volunteering to fulfill a community service requirement on behalf of a company, school, organization or church? ☐ **No** ☐ **Yes** If "Yes", please indicate the name of the company, school, organization or church

Are you currently a student? ☐ **No** ☐ **Yes** If "Yes", please indicate the name of the school you currently attend and your major:

If you are a student completing a practicum at EMU for a course requirement, please indicate the following:	Instructor:
Course Name and Number:	# of Hours required to complete:

INTERESTS **Please indicate which activities you are interested volunteering for at the Autism Collaborative Center by numbering them from 1 – 7, with 1 being most interested.**

_____ Child Care ____ Fundraising _____ Marketing/Promotions _____ Office Assistance

_____ Saturday Events ____ Campus/Community Outreach ____ Academic Support/Tutoring

AVAILABILITY **Please indicate how often you are available to volunteer for the Autism Collaborative Center**

_____ Weekly ____ Monthly _____ Weekends Only _____ Occasionally

RELEASE ***Please read this information carefully before signing below!***

In return for receiving permission from the Autism Collaborative Center (ACC) of Eastern Michigan University to allow to me participate as a volunteer at an Agency sanctioned event, or at an Agency affiliated site, I agree to assume all risks of loss and injury that may arise out of participation. I hereby FULLY and FINALLY RELEASE, DISCHARGE and agree to INDEMNIFY and HOLD HARMLESS the Autism Collaborative Center and their respective agents, officers, employees and affiliates from any and all liability, claims, demands and causes of action whatsoever, related to any loss or damage to my person or property including injury, death and any and all losses, damage, expense, costs, fees and/or liabilities of whatsoever kind or nature in connection therewith whether anticipated or unanticipated. This release shall be binding on me, my heirs, successors, assigns, administrators and/or executors.

I understand that engaging in Autism Collaborative Center's volunteer activities may expose me to dangers both from known and unknown risks. I realize that working on this project may involve the use of tools as well as intense physical labor. I am aware of the risks and hazards inherent in participating and do hereby assume sole responsibility for all such risks and waive all recourse against the Autism Collaborative Center.

I agree to abide by the guidelines and directions of the Autism Collaborative Center while taking part in this project. I hereby acknowledge that I read, understood and do voluntarily sign the foregoing release.

SIGNATURE:_____ **DATE:** _____

PHOTOGRAPHIC RELEASE

Do you object to the Autism Collaborative Center photographing you during the course of your participation as a volunteer and using the images for ACC related publicity purposes? ☐ No, I do not object ☐ Yes, I object **

**** PLEASE ADVISE THE PROJECT LEADER AND PHOTOGRAPHER OF YOUR OBJECTIONS IF YOU HAVE CHECKED "YES".**

Print Name: Signature: Date:

Signature of Parent/Guardian (if volunteer is under age 18): Date:

Relationship to Volunteer:

BACKGROUND AUTHORIZATION REQUEST

Authorization

By signing this authorization, the applicant grants permission to the MSP and any other public or private entity to conduct a background check for the express purpose of determining eligibility for working minor children or in some cases, adults with disabilities, as part of the Autism Collaborative Center. The background search will include, but is not limited to, arrests, criminal charges, criminal convictions, and any information regarding contact with a criminal justice agency.

Applicant Information

Name: Last	First	Middle

Date of Birth : / /

Sex: ☐ Male ☐ Female

Race

☐ White ☐ Black (African American) ☐ American Indian/ Alaskan Native

☐ Hispanic ☐ Asian/ Pacific Islander ☐ Other:

Signature : Date:

This information is confidential. Disclosure of confidential information is protected by the Privacy Act of 1974 (5 U.S.C. § 552a), as amended.

AUTHORITY: 1974 PA 163; **COMPLIANCE:** Voluntary

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Confidentiality Agreement

All EMU Autism Collaborative Center client information whether contained in a client's Clinic record, or in any other medium, including audio, videotapes, or any computer system is strictly confidential. Disclosing, accessing, or permitting access to confidential client information without proper authorization is a violation of EMU Autism Collaborative Center policy, state laws and Federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and unauthorized disclosures may result in disciplinary action. In addition, disclosing, accessing, or permitting access to confidential Protected Health Information (PHI) without proper authorization may also subject the violator to civil and/or criminal penalties for violation of state laws and HIPAA. Billing and financial management information is also to be held in strict confidence and is not to be disclosed without written authorization by the client.

I certify that as a **practicum student, staff, volunteer, or faculty member** of the EMU Autism Collaborative Center, I understand the statements above and am aware of the confidential nature of the client's PHI. I understand and agree that in the performance of my duties at the EMU Autism Collaborative Center, I am obligated to respect client privacy and to protect client PHI from unauthorized use and/or disclosure. This includes only accessing client's PHI on a need to know basis related to treatment, payment, and health care operations, or training. I understand that when the audio or videotapes for a client are in my possession, I assume total responsibility for the confidential retention and viewing of these tapes. I understand that the unauthorized use and/or disclosure of information from the client's record, audio or videotapes, or from any computer system may result in disciplinary action up to and including dismissal, in accord with the policy outlined in the EMU Autism Collaborative Center Policy and Procedures Manual, and may further subject me to civil and criminal penalties under HIPAA.

I acknowledge that I may have access to confidential client information. By signing this statement, I agree to follow the guidelines below, and as further detailed in the EMU Autism Collaborative Center Policy and Procedures Manual.

The identity of clients, or information that would reveal the identity of clients, cannot be revealed without the specific permission of the client. The only exceptions to this are cases in which the client may be dangerous to themselves or others and in cases of child abuse. In such situations, there may be legal requirements that responsible agencies be informed. There are also certain legal proceedings in which case notes and other records can be ordered to be released by the courts. Clinicians must familiarize themselves with, and adhere to, confidentiality procedures of the Clinic and the laws of the State. Case material discussed in class must be prepared in such a way that client confidentiality is maintained.

_____ _____

Name (print) Position in Clinic

_____ _____

Signature Date