



Mentor Hamilton Application Instructions

Please fill out the following forms and return to Mentor Hamilton:

- Mentor Hamilton Application
- NUSD Volunteer Application with TB Risk Assessment Form
- Request for Live Scan Service (fingerprints). Take the attached Live Scan form to a UPS store to obtain your fingerprints and the report will be sent directly to NUSD

Please have 3 people complete a Mentor Hamilton Reference Request on your behalf. Three copies of the form are attached. Please have your reference send the form directly to Mentor Hamilton by fax, mail or email.

- Mentor Hamilton Reference Request

Please do not hesitate to contact us should you have any questions about this process.

Thank you!

Send completed information to:

Mentor Hamilton
5530 Nave Drive
Novato, CA 94949
Phone: 415-883-4691
Fax: 415-883-7745
Email: cpace@nUSD.org



Mentor Application

Name: _____ Email: _____

Address: _____ City/State/Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer: _____

Employer's Address: _____

How did you hear about Mentor Hamilton?

1. Have you ever been convicted or plead guilty to any crime(s): ____ yes ____ no If yes, please explain:

2. Has any other youth program refused you as a volunteer? ____ yes ____ no If yes, please explain:

(Answering yes to questions 1 and 2 above does not necessarily preclude you from becoming a mentor. Please be honest with the information you supply. Use the back of the paper if necessary.)

3. Special professional training, skills, hobbies and interests:

4. Community Affiliations (clubs, service organizations, etc.)

5. Previous volunteer experience (please include name of organization, contact name and telephone number):

6. What experience do you have in working with/raising children ?

7. What interests you about becoming a mentor to a child?

8. What do you hope the experience of mentoring a child will be like?

9. Special certificates (e.e. CPR, medical, ecc units, etc.) _____

10. Do you have children at Hamilton School? ____yes ____no

11. Other than English, what language(s) do you speak? _____

12. Personality traits: (Circle those which best describe you.)

friendly funny quiet serious patient reserved talkative musical
outgoing athletic artistic organized curious studious thoughtful other?

13. ____ I give permission **OR** ____ I do not give permission for Mentor Hamilton to share my email address with my mentee's teacher/counselor, so that I can be advised about field trips, etc.

14. ____ I give permission **OR** ____ I do not give permission for Mentor Hamilton to include my ____name, ____email address, ____phone number in the roster of mentors, to be used internally within the program.

References. Please send a reference form to each of these three people; have them complete and return the forms to the Catherine Pace @ cpace@nusd.org

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

As a condition of volunteering, I give Mentor Hamilton permission to conduct a background check on me, which may include contacting my references and may include a review of sex offender registries, child abuse and criminal history records and a DMV check. I understand that, if appointed, my position is conditional upon Mentor Hamilton's receiving no inappropriate information on my background check. I hereby release and agree to hold harmless from liability Mentor Hamilton, the officers, employees and volunteers thereof, or any person or organization that may provide such information. I also understand that regardless of previous appointments, Mentor Hamilton is not obligated to appoint me a volunteer position.

Applicant signature: _____ **Date:** _____

Note: Mentor Hamilton will not discriminate against any person on the basis of race, creed, religion, color, national origin, marital status, gender, sexual orientation or disability.

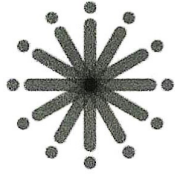
Mentor Hamilton staff use only:	
Background checks completed by NUSD	Date check was completed _____
Attach to the top of application: copies of background check reports that reveal convictions of the applicant.	
Training Date: _____	
Match Made: Date: _____ School Site: _____ Mentee Name: _____	

Return application:

scan and email to: cpace@nusd.org

OR fax to 415 883-7745

OR mail to Hamilton School 5530 Nave Drive, Novato Ca 94949



NOVATO
UNIFIED
SCHOOL
DISTRICT

Jan La Torre-Derby, Ed.D.
Superintendent

Francesca Whitcomb
Director, Human Resources

1015 7th St
Novato, CA 94945

T: (415) 493.4220
F: (415) 897.1531
www.nusd.org

VOLUNTEER APPLICATION

This application must be completed if you wish to be a Site-Based Volunteer, Field Trip, and/or Overnight Field Trip Chaperone. The following information is required:

School/Department: MENTOR HAMILTON

Name: _____

Address: _____

Street

City

Zip

Telephone#: _____ Email: _____

All items below must be completed before being cleared to volunteer.

☐ **Site-Based Mentor:**

- ☐ Volunteer Application
- ☐ Proof of Identification: i.e. Driver's License or Passport
- ☐ [TB Risk Assessment Form](#) (or cleared TB test)
- ☐ Fingerprint clearance ([Live Scan Form](#))

Volunteer Conditions and Confidentiality

- All student information should be treated confidentially. I am required to maintain confidential all information that I may obtain directly or indirectly.
- Any information learned from a student should be held in strict confidence except if the student confides he/she is the victim of abuse and/or involved in any illegal activity.
- I am to conduct myself in a manner that will not be distracting from the educational process.
- As a matter of safety, I will not bring siblings and/or children not enrolled in the classroom during any volunteer hours (i.e. class parties, field trips, etc.).
- All accidents/injuries must be reported immediately to the Principal or Principal's designee.
- School staff is responsible for discipline and grading will be handled by the student's teacher.
- I will sign in and out at the school office and wear a school visitor badge at all times while volunteering.
- While volunteering, I will not bring, distribute or consume any prohibited substances (i.e. tobacco, alcoholic beverages, marijuana, etc.).
- I understand I may be held personally responsible for any activity that could be considered gross negligence in the performance of my responsibilities.
- ☐ All documents must be turned in to School Site Office Manager **OR** to Human Resources
- ☐ Office Managers will forward Volunteer Applications to HR
- ☐ Please note TB information will be on a list shared with office managers.

I have read and understand each of the above conditions and I agree to abide by them. Consistent with applicable law and District Policy, the District shall not authorize any registered sex offenders to volunteer in classrooms and, drive and/or chaperone students on field trips.

Volunteer Signature

Date



REQUEST FOR LIVE SCAN SERVICE
(Public Schools or Joint Powers Agencies)

Print Form

Reset Form

Applicant Submission

ORI: A0523 Type of Applicant: ☐ Classified School Employee ☐ Credentialed School Employee
Code assigned by DOJ

The following selections are for Public Schools only:

☐ License, Certification, Permit ☐ Peace Officer ☐ Law Enforcement Officer ☐ Volunteer

Type of License/Certification/Permit OR Working Title: _____

(Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

NOVATO UNIFIED SCHOOL DISTRICT
Agency Authorized to Receive Criminal Record Information

01897
Mail Code (five-digit code assigned by DOJ)

1015 SEVENTH STREET
Street Address or P.O. Box

JENNIFER ALBINI
Contact Name (mandatory for all school submissions)

NOVATO CA 94945
City State ZIP Code

4154934246
Contact Telephone Number

Applicant Information:

Last Name _____
Other Name (AKA or Alias) Last _____

First Name _____ Middle Initial _____ Suffix _____
First _____ Suffix _____

Date of Birth _____ Sex ☐ Male ☐ Female

Driver's License Number _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Billing Number APPLICANT MUST PAY
(Agency Billing Number)

Place of Birth (State or Country) _____ Social Security Number _____

Misc. Number _____
(Other Identification Number)

Home Address _____
Street Address or P.O. Box

City _____ State _____ ZIP Code _____

Your Number: NUSD2165
(OCA Number (Agency Identifying Number))

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number _____

Live Scan Transaction Completed By:

Name of Operator _____

Date _____

Transmitting Agency _____

LSID _____

ATI Number _____

Amount Collected/Billed _____



California School Employee Tuberculosis (TB) Risk Assessment Questionnaire



(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.[^]
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____

Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)

☐ Yes

- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked

☐ One or more sign(s) or symptom(s) of TB disease

- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month

- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ Close contact to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

[^]The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).



Certificate of Completion Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X _____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

**Mentor Hamilton
Mentor Reference**

_____ is applying to be a volunteer mentor with **Mentor Hamilton, at Hamilton School**. Your evaluation of this potential volunteer is appreciated. Please be candid in your assessment and provide information that will assist Mentor Hamilton in providing our children with safe and effective mentors. Please use the back if you need more room. Thank you.

1. How are you acquainted with the potential mentor and how long have you known this person?
2. In what setting have you observed and/or worked with this person?
3. What are the major strengths of the potential mentor?
4. In your opinion, does the potential mentor have the personality and capability/potential to be effective as a mentor for children? Please explain.
5. Do you have any reservations about recommending this candidate as a mentor for children? ___ No ___ Yes
If you indicated "yes" please explain:
6. Please circle one number for each item indicating the relative strengths and weaknesses demonstrated by the potential mentor. The scale ranges from 5 (outstanding) to 1 (shows a definite weakness).

	High				Low
a. accepts responsibility	5	4	3	2	1
b. is self-motivated	5	4	3	2	1
c. is punctual	5	4	3	2	1
d. communicates well with others	5	4	3	2	1
e. follows through with commitments	5	4	3	2	1
f. accepts constructive feedback	5	4	3	2	1
g. respects others	5	4	3	2	1
h. solves problems creatively	5	4	3	2	1
i. is able to handle stressful situations	5	4	3	2	1
j. is willing to consider alternatives	5	4	3	2	1
k. is compassionate	5	4	3	2	1

Print Name: _____ Signature: _____ Date: _____

Address: _____

Email: _____ Phone#: _____

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