NOVATO UNIFIED SCHOOL DISTRICT

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# VOLUNTEER PACKET

School/Department: _____

Name: _____

Address: _____
Street City Zip

Telephone#: _____

Email Address: _____

- **Identification: ATTACH one copy of each required document – A & B (two total)**

  **A. <u>ONE of the following</u>:**
  - Driver's License
  - US Military Card

  **AND**

  **B. <u>ONE of the following</u>:**
  - United States Passport
  - Original Social Security Card
  - Birth Certificate
  - Certificate of US Citizenship or Naturalization
  - Alien Registration Card with Photo
  - INS Employment Authorization Form

- **Life Scan Form:** for fingerprints. Please submit form to HR
- [1]***TB Verification**: Please submit to HR
- [2]***COVID Vaccine Verification**: Please submit to HR

_____
Signature

_____
Date

[1] *Please note TB and COVID information will be on a list shared with office managers
[2] *If you do not have an updated TB test or have not been vaccinated for COVID, you will not be able to volunteer for NUSD

STATE OF CALIFORNIA
BCIA 8016A
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

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

Print Form | Reset Form

***Applicant Submission***

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

***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 (City) CA (State) 94945 (ZIP Code)

4154934246
Contact Telephone Number

Applicant Information:

Last Name | First Name | Middle Initial | Suffix

Other Name (AKA or Alias) Last | 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

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency

# 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):**