

Please Return to:
 TeamMates Mentoring Program
 11850 Nicholas Street, Suite 120
 Omaha, NE 68154

TeamMates Mentoring Program Mentor Application

Office Use Only
 Mentor ID# _____

Name _____ Birth Date _____

Maiden Name or other Legal Names _____ School Preference _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail address _____ Age _____ Gender _____

The following information is requested for input into our database and is not a determinant of eligibility to be a mentor.

Ethnic Background (Choose all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic/Latino	What is your highest level of education completed? <input type="checkbox"/> High School <input type="checkbox"/> BA/BS Degree <input type="checkbox"/> High School Diploma <input type="checkbox"/> Master's Degree <input type="checkbox"/> College Courses <input type="checkbox"/> PhD <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Other _____
How did you hear about TeamMates? <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Television <input type="checkbox"/> Billboards <input type="checkbox"/> Personal Friend/Acquaintance <input type="checkbox"/> Other _____	
Identify all service organizations, faith-based entities or community groups you are affiliated with: <input type="checkbox"/> Faith Based _____ <input type="checkbox"/> Service Organization _____ <input type="checkbox"/> Business/Workplace _____ <input type="checkbox"/> Other: _____	
Please select one of the following that best categorizes your current employment (choose ONE only): <input type="checkbox"/> Managerial/Professional (teacher, doctor, social worker etc) <input type="checkbox"/> Technical/Sales/Administrative <input type="checkbox"/> Service <input type="checkbox"/> Military <input type="checkbox"/> Law Enforcement/Justice <input type="checkbox"/> Religions <input type="checkbox"/> Other (specify) _____	
NAME OF EMPLOYER _____ OCCUPATION _____	

Do you speak a foreign Language? No Yes What language? _____

Emergency Contact: Name _____ Phone Number _____

Special medical conditions the school contact should be aware of:

Please provide the following information on 3 references. ** If you are applying to be a mentor with the Lincoln Public Schools, please include a third reference other than family.

	**Family Reference	Friend Reference	Employer Reference
Name			
Address			
City /State /Zip Code			
Home Phone			
Work Phone			
Relationship			
E-mail (opt.)			

I give permission for TeamMates to run a criminal and child abuse check. * Background checks will be run every three years.

Signed: _____ **Date:** _____



TeamMates Mentor Agreement

I, _____(your name) acknowledge that if accepted as a TeamMate Mentor, I agree to abide by the rules and regulations of the TeamMates Mentoring Program. I understand that the program involves spending time weekly at the assigned school with my student during the school year. I will be committed to one year in the program and will have the opportunity to renew for another year. I have not been convicted or had final disposition of a conviction of any felony or misdemeanor classified as an offense against a person or family, or public indecency, or a violation involving a state or federally controlled substance. I am not currently under indictment. **I give permission for TeamMates to conduct a periodic criminal background check and child/adult abuse inquiry.** Further, I hereby fully discharge school personnel and participating companies or organizations from any and all liability, claims, causes of action, costs and expenses which may be attributable to my participation in the TeamMates Mentoring Program.

In connection with my application to volunteer, I understand that references may be requested that will include information as to my character, work habits, performance and experience.

I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by One Source, The Background Check Company or its agent, to furnish the information described above. I understand that in the event a decision is made based upon the results of my background check, a report will be furnished to me upon my request.

I also agree to the following:

- To actively participate in training sessions before beginning.
- To be on time for scheduled meetings.
- To sign in on the volunteer registration sheet at the school prior to each visit.
- To notify the school office if I am unable to keep my regularly scheduled meeting with my youth TeamMate.
- To engage in the one-to-one mentoring with an open mind.
- To accept assistance from the student's teachers and TeamMates Mentoring Program Coordinator.
- To keep discussions with the student confidential, except to inform the teacher or program coordinator about situations that negatively affect the student's health or welfare.
- To ask the program coordinator when I need assistance or do not understand something.
- To notify the program coordinator of any changes in my employment, address, or phone number.
- To notify the program coordinator of any problems or difficulties with the relationship.
- To notify TeamMates if any criminal charges brought against me while I am a TeamMates Mentor.
- To cooperate with the program's policies and procedures.
- To allow TeamMates to use my photograph/image or likeness as needed.

I understand the TeamMates Mentoring Program reserves the right to deny acceptance to any mentor and to terminate a mentor from the program.

I have read the above statements and agree to the contents. To the best of my knowledge and belief, all statements in my application are true and accurate.

Signature

Date

12/02/2008

AUTHORIZATION FOR RELEASE OF CHILD ABUSE INFORMATION

This form must be used to authorize release of child abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person about whom information is requested. Send the original to the Central Abuse Registry, Iowa Department of Human Services, 1305 E Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114.

PART A: To be completed by the person requesting information.				
1.	Requester One Source, The Background Check Company			
	Address PO Box 24148			
	City Omaha	State NE	Zip Code 68124	Phone Number 1-800-608-3645
	The information concerns:			
2.	Name (first, middle initial, last)			
	Maiden Name or Alias (if applicable)		Birth Date	Social Security Number
	Address			
	City	State	Zip Code	County
3.	What is the purpose of your request for child abuse information? Employment			
	I have read and understand the legal provisions for handling child abuse information which are printed on the back of this form.			
4.	Signature <i>Paara Belyea</i>			Date
PART B: To be completed by the person authorizing the Department of Human Services to release child abuse information.				
I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse Registry in a child abuse report as having abused a child (Iowa Code 235A.15). To the best of my knowledge, all or part of the information contained in Part A of this form is correct.				
Signature			Date	
PART C: To be completed by the Central Abuse Registry or designee.				
1. <input type="checkbox"/> The person named in item A-2 is listed on the Child Abuse Registry as having abused a child.				
2. <input type="checkbox"/> The person named in item A-2 is not listed on the Child Abuse Registry as having abused a child.				
3. <input type="checkbox"/> The request for information is denied because the form is incomplete				
Signature			Date	
Comments				

Iowa Department of Human Services

Authorization for Release of Dependent Adult Abuse Information

This form must be used to authorize release of dependent adult abuse information when the person requesting the information does not have independent access to it in Iowa law. Complete a separate form for each person about whom information is requested. Send the original to the Central Abuse Registry, Iowa Department of Human Services, 1305 E Walnut Street, 5th Floor, Des Moines, IA 50319-0114 or fax to 515-242-6884.

To be completed by the person requesting information:

Requester One Source, The Background Check Company			
Address PO Box 24148			
City Omaha	State NE	Zip Code 68124	Phone Number 1-800-608-3645

The information concerns:

Name (first, middle initial, last)			
Maiden Name or Alias (if applicable)	Birth Date	Social Security Number	
Address			
City	State	Zip Code	County

What is the purpose of your request for dependent adult abuse information? Employment

I have read and understand the legal provisions for handling dependent adult abuse information that are printed on the second page of this form.

Signature <i>Laura Belyea</i>	Date
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To be completed by the person authorizing the Department of Human Services to release dependent adult abuse information:

Signature	Date
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To be completed by the Central Abuse Registry or designee:

- The person named above is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- The person named above is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- This request for information is denied because the form is incomplete.

Signature	Date
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Comments:

LEGAL PROVISIONS FOR THE HANDLING OF CHILD ABUSE INFORMATION

Redissemination of Child Abuse Information (Iowa Code 235A.17)

A person, agency, or other recipient of child abuse information shall not redisseminate this information. However, redissemination is permitted when all of the following conditions apply:

- ◆ The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- ◆ The person to whom the information would be redisseminated would have independent access to the same information under Iowa Code Section 235A.15.
- ◆ A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- ◆ The written record is forwarded to the Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code 235A.21)

- ◆ Any person is guilty of a criminal offense when the person:
 - Willfully requests, obtains, or seeks to obtain child abuse information under false pretense.
 - Willfully communicates or seeks to communicate child abuse information to any agency or person except in accordance with Iowa Code Sections 235A.15 and 235A.17.
 - Is connected with any research authorized pursuant to Iowa Code Section 235A.15 and willfully falsifies child abuse information or any records relating to child abuse.
- ◆ Upon conviction for each offense, the person shall be punished by a fine of up to \$1,000 or imprisonment for not more than two years, or by both fine and imprisonment.
- ◆ Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child abuse information except in accordance with Iowa Code Sections 235A.15 and 235A.17 shall be fined not more than \$100 or be imprisoned not more than ten days for each such offense.
- ◆ Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapter 235A shall be grounds for the immediate withdrawal of any authorized access that the person might otherwise have to child abuse information.

Legal Provisions for the Handling of Dependent Adult Abuse

Redissemination of Dependent Adult Abuse Information, Iowa Code 235B.8

A person, agency, or other recipient of dependent adult abuse information shall not redisseminate this information. However, redissemination is permitted when all of the following conditions apply:

- The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- The person to whom the information would be redisseminated would have independent access to the same information under Iowa Code section 235B.6.
- A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Registry within 30 days of the redissemination.

Criminal Penalties, Iowa Code 235B.12

Any person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain dependent adult abuse information under false pretense.
- Willfully communicates or seeks to communicate dependent adult abuse information to any agency or person except in accordance with Iowa Code sections 235B.6 through 235B.8.
- Is connected with any research authorized pursuant to Iowa Code section 235B.6 and willfully falsifies dependent adult abuse information or any records relating to dependent adult abuse.

Upon conviction for each offense, the person shall be punished by a fine of up to \$1,000 or imprisonment for not more than two years, or by both fine and imprisonment.

Any person who knowingly, but without criminal purposes, communicates, or seeks to communicate dependent adult abuse information except in accordance with Iowa Code sections 235B.6 and 235B.8 shall be fined not more than \$100 or be imprisoned not more than ten days for each such offense.