DURANT COMMUNITY SCHOOL DISTRICT
VOLUNTEER APPLICATION

Directions: Please complete this School Volunteer Application as completely as possible. If you are not employed at present, omit the portion related to employment.

Please return this form to: Duane Bennett, Superintendent

If you have any questions call 563-785-4432

NAME:_____

SOCIAL SECURITY NUMBER:_____DATE OF BIRTH:_____

ADDRESS:_____

TELEPHONE: Home_____Work_____

OCCUPATION:_____ EMPLOYER:_____

FORMER EMPLOYER:_____

CERTIFICATION/LICENSES HELD (IF APPLICABLE)_____

SKILLS:_____

MAJOR AREA OF TRAINING_____

SPECIAL INTERESTS PERTAINING TO EDUCATION:_____

LANGUAGES SPOKEN:_____

I am especially interest in volunteering in this area or activity._____

_____

GRADE LEVEL PREFERRED:_____

SUBJECT/ACTIVITY PREFERRED:_____

DAYS/TIMES AVAILABLE:_____

REFERENCES—LIST 2:_____

PHONE

_____

PHONE

VOLUNTEER STATEMENT: I am applying to be a school volunteer. I authorize the District to conduct a background check and to contact references.

VOLUNTEER SIGNATURE:_____ DATE:_____

STATUS OF APPLICATION

_____APPROVED _____NOT APPROVED

DATE: _____

DISTRICT SIGNATURE:_____

Please make sure that you have the district's approval before beginning to volunteer!

onesource®
The Background Check Company

APPLICANT DISCLOSURE AND AUTHORIZATION FORM

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

[Employer] ("The Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history including current position, worker's compensation injuries, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by **[One Source The Background Check Company, PO Box 24148 Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com]** or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by **[One Source The Background Check Company, PO Box 24148 Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com]**, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

PLEASE PRINT LEGIBLY

Last Name _____ First _____ Middle _____

Other Names/Alias _____

Social Security #* _____ Date of Birth* (MM/DD/YYYY) _____

Driver's License # _____ State of Driver's License _____

Present Address _____ Phone Number _____

City/State/Zip _____

All Previous Addresses in the Last Seven Years _____

_____

_____

Signature _____ Date _____

*This information will be used for background screening purposes only and will not be used for any other purpose.

Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult 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 for whom information is requested and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

☐ Child Abuse Registry ☐ Dependent Adult Abuse Registry ☒ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☐ Fax ☒ Email

Section 1: *To be completed by the person or agency requesting the information.*

Requester: Last	First	Agency Name		Telephone Number
		One Source the Background Check Company		(800) 608-3645
Address: PO Box 24148				Fax Number: (800) 929-8117
City: Omaha		State: NE	Zip Code: 68124	Email: iaregistry@onesourcebackground.com

List the name and address of the person whose information is being requested:

Name (last, first, middle)		Birth Date	Social Security Number	
Address	City	County	State	Zip Code

List maiden name, previous married names, and any alias:

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

Employment

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

Signature of Requestor	Date
Nick Jasa	

Section 2: *To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information.*

I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (Iowa Code section 235A.15) or dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct.

Signature of Person Authorizing	Date

Section 3: *To be completed by the Central Abuse Registry or designee.*

☐ The person whose information is being requested is listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.

☐ The person whose information is being requested 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 of Registry Staff or Designee	Date

Comments

Social Security Administration

Form Approved
OMB No. 0960-0760

Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:

I want this information released because I am conducting the following business transaction:

Reason (s) for using CBSV: (Please select all that apply)

- ☐ Mortgage Service
- ☐ Banking Service
- ☐ Background Check
- ☐ License Requirement
- ☐ Credit Check
- ☐ Other

with the following company ("the Company"):

Company Name: One Source The Background Check Company

Company Address: 10842 Old Mill Rd, Suite 6, Omaha, NE 68154

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified.

The name and address of the Company's Agent is:
Computer Information Development LLC
713 W. Duarte Rd #106, Arcadia, CA 91007

I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to $5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Relationship (if not the individual to whom the SSN was issued): _____

Contact information of individual signing authorization:

Address _____

City/State/Zip _____

Phone Number _____

Privacy Act Statement

SSA is authorized to collect the information on this form under Sections 205 and 1106 of the Social Security Act and the Privacy Act of 1974 (5 U.S.C. § 552a). We need this information to provide the verification of your name and SSN to the Company and/or the Company's Agent named on this form. Giving us this information is voluntary. However, we cannot honor your request to release this information without your consent. SSA may also use the information we collect on this form for such purposes authorized by law, including to ensure the Company and/or Company's Agent's appropriate use of the SSN verification service.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to complete the form. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send to this address only comments relating to our time estimate, not the completed form.***

TEAR OFF

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf