Please Print Legibly—Allow 2 weeks for processing.

Volunteer Application

Attn: Waynesville R-VI School District
Community Resource Office (CRO)
12751 Pulaski Ave., Bldg 8021
Fort Leonard Wood, MO 65473
(573) 842-2250 / community@waynesville.k12.mo.us

Name: _____ _____ Date: _____
Last First

Address: _____
Street City, State & Zip Code

Best Contact Phone Number: _____ Alternate Phone Number: _____

Email Address (required): _____

Are you new to volunteering in the Waynesville R-VI School District or a returning volunteer? ☐ New ☐ Returning

Do you have access to Fort Leonard Wood? ☐ YES ☐ NO

Select your affiliation with the Waynesville R-VI School District:

☐ Parent/Grandparent ☐ Student who is interested in volunteering ☐ PIE Unit: _____ ☐ Other: _____

Select school(s) where you want to volunteer:

☐ Williams Early Childhood Center ☐ Parker Education Center ☐ East Elementary ☐ Freedom Elementary ☐ Partridge Elementary
☐ Pick Education & Volunteer Center ☐ Thayer Elementary ☐ Wood Elementary ☐ Waynesville Six Grade Center ☐ Waynesville Middle School
☐ Waynesville High School ☐ Waynesville Career Center

Select your current military affiliation:

☐ Active-Duty ☐ Veteran ☐ Military Dependent ☐ Family Member of Veteran ☐ N/A

Preferred type of volunteer service: (mark all that apply)

Level 1 Volunteer (not to be left alone with students): ☐ Volunteer in a school or school activity ☐ Library/Book Fairs ☐ Snack in a Pack
☐ Rocking Chair Reader ☐ PIE Partner ☐ Classroom (not left alone w/students) ☐ Field Trip (your child only) ☐ Other: _____

***Level 2 Volunteer (may work with individual/small groups of students):**
☐ Classroom (work with small group) ☐ Field Trip (responsible for small group) ☐ WayConnect Mentor ☐ Partners on Patrol

Are you interested in serving in the AmeriCorps Program? ☐ YES ☐ NO

Background Check Policy

Volunteers must complete a background check (submitted by the school district) which is good for 12 months. Background checks help ensure the safety of everyone in our schools, and are processed at no cost to you. *Both sides/pages of this application must be completed in order to be processed*. Volunteers will be contacted and *notified via email* when their application has been approved, therefore it is important that the *email address provided is legible*.

***Level 2 Volunteers** must have prior approval and require additional background check and additional training. The need for Level 2 Volunteers will be identified by the district when circumstances occur and a district staff member will reach out at that time to request the completion of an additional background check.

Student and staff volunteers

No background check required. Contact the Community Resource Office for any questions. Tel. (573) 842-2250. Email: community@waynesville.k12.mo.us

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Signature: _____

ALL VOLUNTEERS ARE REQUIRED TO FOLLOW DISTRICT POLICIES AND PROCEDURES

Only one application needs to be submitted per person, regardless of the number of children you have enrolled in the district.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.** Register only once!

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  Agency Name: _____
- ☐ Child Care
- ☐ Missouri Foster Parent/Family Member of Foster Parent
  Children's Division County Office: _____
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☑ Voluntary *(Select voluntary if no other registration type applies.)*

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

NOT APPLICABLE

A one-time registration fee of **$15.00** applies to all categories except Missouri Foster Parents, who m

NOT APPLICABLE

Have you or an imm ☐ Yes ☐ No

If Yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

SOCIAL SECURITY NUMBER ~~(Mail copy of card with form.)~~ To verbally share please call 573-842-2250

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PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

BIRTH NAME (LIST FULL NAME)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

NOT APPLICABLE

☑ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☑ Volunteer
- ☐ Other (Explain:_____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)