VOLUNTEER APPLICATION AND SERVICE AGREEMENT COVER SHEET

Incomplete applications, including failure to disclose accurate information regarding any/all criminal convictions, will be **automatic grounds for denial** of your application. If you have any questions or need assistance with this application packet, please contact the Community Resources Manager prior to submission.

Please provide all information requested below

☐ New Volunteer ☐ Renewal ☐ Gate Clearance ☐ Brown Card

Volunteer Applicant: _____

Institution: _____

Service Group Name(s): _____

For Renewals, include length of continuous volunteer service (example, 1 yr. 5 yr. etc.) _____

☐ **Attachment A**: CDCR 966 (Rev. 01/21) Volunteer Application and Service Agreement

Shall include the following attachments: Resumes, Employment History, Academic Enrollments, Community Participation Certifications, Licenses, Ordination Documents, or Reference Letters to Wardens.

☐ **Attachment B**: CDCR 181 (Rev. 10/14) Primary Laws, Rules, and Regulations Regarding Conduct and Association with State Prison Inmates.

☐ **Attachment C**: CDCR 894 (09/19) Emergency Notification Information

☐ **Attachment D:** CDCR 7336 (Rev. 03/20) Employee Tuberculin Skin Test (TST) and Evaluation

☐ **Attachment E**: CDCR 7354 (Rev. 07/15) TB Infectious Free Staff Certification

☐ **Attachment F**: CDCR 1049 (08/08) Certification of Volunteer Participation

☐ **Attachment G:** CDCR 8019 (06/20) Nepotism and Fraternization Policy Acknowledgment

☐ **Attachment H:** CDCR 2301 (Rev. 05/20) PREA Policy Information for Volunteers and Contractors Part A

☐ **Attachment I:** STD 910 (Rev. 10/2019) Essential Functions Health Questionnaire

☐ **Attachment J:** CDCR 1887 (Rev. 08/08) Parent Consent for Participation (if applicable)

All of the above forms must be submitted with this packet.

Volunteer Signature: _____ Date: _____

****Please note specific additional information/forms may be required at various Institutions****

Volunteer Applicant:_____

Institution:_____

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐RENEWAL

VOLUNTEER APPLICATION AND SERVICE AGREEMENT

SECTION I: To be Completed by Applicant (PRINT CLEARLY)

Name _____ Date of Birth: _____
First MI Last (MM/DD/YYYY)

Address: _____
Number and Street Apt. # City State Zip

Email (**optional**): _____

SSN# (**optional**):_____-_____-_____ State Driver's License or Identification # **(required)**:_____Exp.: _____

Passport# _____(If applicable) Exp. Date: _____

Phone # (required): ( ) _____-_____ Cell #: ( )_____-_____ Fax # (optional): ( )_____-_____

Gender: ☐ Male ☐ Female Height:_____ Weight: _____ Eye Color: _____ Hair Color: _____

Occupation: _____

Special Skills/Certificates: _____

Name and address of company/church/organization you will represent as a volunteer (If applicable):_____

_____

1. Have you submitted Live Scan fingerprints to CDCR in the past? ☐ No ☐ Yes (*If yes, provide date and location/institution.)*

_____

2. Do you provide volunteer service at any other CDCR institution? ☐ No ☐ Yes (*If yes, provide date and location/institution.)*

_____

3. Do you visit and/or correspond with any inmates at any other CDCR institution? ☐ No ☐ Yes *(If yes, explain fully and provide inmate name(s), CDCR number(s) and institution(s), attach additional sheets, as needed).*

_____

_____

4. Are you related to any inmate(s) at any CDCR institution? ☐ No ☐ Yes *(If yes, explain fully and provide inmate(s) name(s), CDCR number(s) and institution(s) include additional sheets as necessary).*

_____

_____

Volunteer Applicant:_____

Institution:_____

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐ RENEWAL

5. Have you ever been arrested and/or convicted of any offense? ☐ No ☐ Yes (***If yes, list all detentions, arrests, and/or convictions. Attach additional sheet(s), if necessary.)***

Offense	Approx. Date	Disposition (Dismissed, Probation, Jail, Prison, etc.)	County	State	Country

6. Are you currently on parole or probation? ☐ No ☐ Yes (***If yes, shall be one year free of illegal activity, submit approval letter from RPA or designee, list name, telephone number and county of parole agent/probation officer)***

_____

_____

7. Are you discharged from prison or parole? ☐ No ☐ Yes ***(If yes, shall be one year free of illegal activity, list date of discharge, name of institution, and attach letter addressed to the Warden outlining the circumstances below.)***

_____

_____

(If information is not disclosed or inaccurate information is provided, your application may not be approved)

I certify that:

- No salaries, wages, or unemployment benefits are to be paid for volunteer services.
- There is no Worker's Compensation provided.
- Use of State supplies may be permitted when directed to do so.
- I must attend any required training as directed.
- I have read and understand the CDCR Primary Laws, Rules, and Regulations Regarding Conduct and Association with State Prison Inmates (CDCR Form 181).
- I authorize CDCR to obtain information from law enforcement sources regarding my criminal history.
- I understand that I must notify the Community Resources Manager immediately in the event there is any change to any of the information I have provided.

The information you provide is entered and stored in a secure electronic database for a minimum of three years. By signing this application, you acknowledge and agree to this process.

_____ _____

Applicant's Signature Date

VOLUNTEERS WITH DISABILITIES: If you have special requirements related to your disability (medical implants, prosthetic devices or requiring mobility assistive devices, i.e., crutches, walkers, braces, wheelchairs, battery operated or custom prescribed wheelchairs, guide dog for the visually or hearing impaired, insulin kit with syringes, etc.) you will need to attach a verifying statement from your physician. Volunteers with guide dogs will need to provide the dog's certification paperwork upon visit check-in. The CDCR will make every effort to provide reasonable accommodations for all qualified/eligible volunteers with disabilities in keeping with the safety and security of the institution and the public. If you have any questions and/or concerns, please contact the Community Resources Manager.

Volunteer Applicant:_____

Institution:_____

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐ RENEWAL

SECTION II: To be Completed by CDCR Staff

Purpose of Entry *(Circle specific program):* ☐ Activity Group ☐ Religious

Name of Program: _____

Location of Volunteer Service *(List institution and location, example: chapel, Facility A, classroom #, etc.):*

_____

Duration of volunteer service: (I.e., one, two or more months):_____

Day(s) of Week *(Check)*: ☐M ☐T ☐W ☐Th ☐F ☐S ☐Su Hours _____ Escort: ☐No ☐Yes

TB Test Required: ☐ No ☐ Yes *(Annual TB Testing is required for all volunteers with more than 6 months of volunteer service)*

Print Name/Classification	Signature	Date

COMMUNITY RESOURCES MANAGER
☐ Reviewed and submitted for background clearance

Signature	Date

CUSTODY STAFF

Signature	Date

NLETS Cleared ☐No ☐Yes
NLETS Cleared Date:_____
☐ Needs further review

WARDEN/WARDEN'S DESIGNEE SIGNATURE:

Signature	Date

☐ APPROVED ☐DISAPPROVED

FOR USE BY CRM ONLY

GATE CLEARANCE ONLY ☐

Background clearance (NLETS) Date: _____

Live Scan Date/Location:

_____
(Required after six months of volunteer service)

Verification of TB Test provided:

☐Yes ☐ No ☐ N/A (If less than 6 months):

Date: _____

Copy of Volunteer Emergency Notification (CDC-894) sent to:

Control	☐No	☐Yes
Watch Office	☐No	☐Yes

FOR USE BY PERSONNEL ONLY

VOLUNTEER IDENTIFICATION CARD (ID CARD) ☐

Title: **VOLUNTEER** *(For all volunteer ID Cards)*

Live Scan: _____
(Date/Location required after six months of volunteer service)

Date ID Card Issued: _____
ID Card Expiration Date: _____
Thumb Print Date: _____
ID Picture Date: _____

Copy of Volunteer Emergency Notification (CDC-894) sent to:

Control	☐No	☐Yes
Watch Office	☐No	☐Yes

Comments:

PRIMARY LAWS, RULES, AND REGULATIONS REGARDING CONDUCT AND ASSOCIATION WITH STATE PRISON INMATES
CDCR 181 (Rev.10/14)

Individuals who are not employees of the California Department of Corrections and Rehabilitation (CDCR), but who are working in and around inmates who are incarcerated within California's institutions/facilities or camps, are to be apprised of the laws, rules and regulations governing conduct in associating with prison inmates, Title 15, Section 3285. The following is a summation of pertinent information when individuals not employed by the department (volunteers, media, contractors and their employees and dignitaries) come in contact with prison inmates.

1. Persons who are not employed by CDCR, but are engaged in work at any institution/facility or camp must observe and abide by all laws, rules and regulations governing the conduct of their behavior in associating with prison inmates. Failure to comply with these guidelines may lead to expulsion from CDCR institutions/facilities or camps.

   SOURCE: California Penal Code (PC) Sections 5054 and 5058; California Code of Regulations (CCR), Title 15, Sections 3283, 3285, 3289, 3292 and 3415

2. CDCR does not recognize hostages for bargaining purposes. CDCR has a "NO HOSTAGE" policy and all prison inmates, visitors, non-employees and employees shall be made aware of this.

   SOURCE: PC Sections 5054 and 5058; CCR, Title 15, Section 3304

3. All persons entering onto institution/facility or camp grounds consent to a search of their person, property or vehicle at any time. Refusal by individuals to submit to a search of their person, property or vehicle may be cause for denial of access to the premises or restrictions to visiting or facility access.

   SOURCE: PC Sections 2601, 5054 and 5058; CCR, Title 15, Sections 3173, 3267, 3288, 3289, and 3292.

4. Persons normally permitted to enter an institution/facility or camp may be barred, for cause, by the CDCR Secretary, Director of Division of Adult Institutions (DAI), Warden, Regional Parole Administrator and /or their designees.

   SOURCE: PC Sections 2086, 5054 and 5058; CCR, Title 15, Sections 3283 and 3289

5. It is illegal for an individual who has been previously convicted of a felony offense to enter into CDCR institutions/facilities or camps without the prior approval of the Warden. It is also illegal for an individual to enter onto these premises for unauthorized purposes or to refuse to leave said premises when requested to do so. Failure to comply with this provision could lead to prosecution.

   SOURCE: PC Sections 602, 4570.5 and 4571; CCR, Title 15, Sections 3173, 3283 and 3289

6. Encouraging and/or assisting prison inmates to escape is a crime. It is illegal to bring firearms, deadly weapons, explosives, tear gas, drugs or drug paraphernalia on CDCR institutions/facilities or camp premises. It is illegal to give prison inmates firearms, explosives, alcoholic beverages, wireless communication devices or components thereof, tobacco products, narcotics, or any drug or drug paraphernalia, including cocaine or marijuana.

   SOURCE: PC Sections 2772, 2790, 4535, 4550, 4573, 4573.5, 4573.6, 4574, 4576 and 5030.1; CCR, Title 15, Sections, 3172.1, 3188 and 3292

7. It is illegal to give or take letters from prison inmates without the authorization of the Warden. It is also illegal to give or receive any type of gift and/or gratuities from prison inmates.

   SOURCE: PC Sections 2540, 2541 and 4570; CCR, Title 15, Sections 3010, 3399, 3401, 3424 and 3425

8. In an emergency situation the visiting program and other inmate program activities may be suspended by the Warden or designee.

   SOURCE: PC Sections 2086 and 2601; CCR, Title 15, Section 3383

9. For security reasons, volunteers, media, contractors, dignitaries and guests must not wear clothing that in any way resembles state issued prison inmate clothing (blue denim shirts, blue denim pants).

   SOURCE: CCR, Title 15, Sections 3174 and 3349.2.3(g) (3) (B)

10. Interviews with SPECIFIC INMATES are not permitted. Conspiring with an inmate to circumvent policy and/or regulations constitutes a rule violation that may result in appropriate legal action.

    SOURCE: CCR, Title 15, Section 3261.5

I HEREBY CERTIFY AND ACKNOWLEDGE I HAVE READ THE ABOVE AND FULLY UNDERSTAND THE IMPLICATIONS REGARDING MY CONDUCT AND ASSOCIATION WITH CDCR INMATES. I ALSO UNDERSTAND VIOLATION OF ANY OF THE ABOVE COULD RESULT IN EXPULSION FROM A CDCR INSTITUTION/FACILITY OR CAMP WITH THE POSSIBILITY OF CRIMINAL PROSECUTION.

VOLUNTEER/MEDIA/CONTRACTOR/GUEST NAME AND TITLE (Print)	SIGNATURE	DATE SIGNED

DISTRIBUTION: Original – Warden, Parole Administrator *and/or designee*

STATE OF CALIFORNIA

EMERGENCY NOTIFICATION INFORMATION

CDCR 894 (Rev. 09/19)

Employees are responsible for ensuring this form is updated when changes occur. The person(s) to be notified in case of emerency should be over the age of 18.

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE):		**LAST 4 DIGITS OF SOCIAL SECURITY NUMBER (FOR ID PURPOSES ONLY):**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**
INSTITUTION/FACILITY/PROGRAM AREA AND UNIT:	**PERSONAL EMAIL ADDRESS:**	

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)

NAME (LAST, FIRST, MIDDLE):		**RELATIONSHIP:**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**

ALTERNATE PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)

NAME (LAST, FIRST, MIDDLE):		**RELATIONSHIP:**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**

MEDICAL INFORMATION

PERSONAL PHYSICIAN'S NAME:		**PHONE NUMBER:**
MEDICAL PLAN NAME:	**MEDICAL PLAN CARD NUMBER:**	**MEDICAL FACILITY NAME AND LOCATION:**
SPECIAL MEDICAL CONDITIONS (ALLERGIES, ETC.):		
SPECIAL INSTRUCTIONS:		
EMPLOYEE'S SIGNATURE:		**DATE:**

This information will be kept confidential and used for emergencies only. This form will be filed in your Official Personnel File (OPF) and in the supervisory file.

PERSONNEL OFFICE USE	
REVIEWER'S PRINTED NAME:	
BIS KEY DATE:	**PHONE NO.:**

DISTRIBUTION **Original:** OPF **Copy:** Supervisor File

EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION

CDCR 7336 (Rev. 03/20)

Confidential Employee Medical Information

INSTRUCTIONS: Tuberculosis (TB) screening must be performed by a licensed health care provider whose legally authorized scope of practice allows them to conduct medical examinations and/or the Mantoux TST in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) to determine if a person has TB infection or disease.

Employee (Complete Section 1. Type or print clearly.)

Section 1	**Employee Information**	
Employee Full Name (First, MI, Last)		Gender ☐ Male ☐ Female ☐ Non-binary
Birthdate (MM/DD/YYYY)	PERNR	New Employee/Cadet? ☐ Yes ☐ No
Institution/Facility/Program	Unit/Location	Department (If not CDCR)
Employee Signature		Date

Health Care Provider (Complete Sections 2–7, as required. See instructions on Page 2 of 2.)

Section 2 TB History and Treatment (Private providers, please attach documentation of prior history.)

History of treatment of TB infection or disease: ☐ Yes ☐ No If yes, complete Section 6.

Date of results of previous TST: _____ Induration _____mm ☐ Not applicable

Date and results of previous Interferon-Gamma Release Assay (IGRA): _____ ☐ Not applicable

Treatment: ☐ No ☐ Yes If yes, type of drug prescribed: _____ Start and stop dates of drug: _____

Notice: HIV and other medical conditions may cause a TST to be negative when TB infection is present.

Section 3	**Tuberculin Skin Test (TST) Administration**			
TST ☐ Yes ☐ No	☐ Tubersol Lot #: _____ ☐ Aplisol Expiration Date: _____	TST Administered By (Print Name)	Signature	Date
Injection Site ☐ Left Forearm (LFA) ☐ Right Forearm (RFA)	Injection Date and Time	Interpretation ☐ Positive ☐ Negative	TST Result Induration: _____ mm	Date and Time of Symptom Evaluation

Section 4	**TB Blood Test**		
TB Blood Test ☐ Yes ☐ No	TB Blood Draw Date and Time	TB Blood Test Results ☐ Positive ☐ Negative	Date and Time of Results
TB Blood Test Administered By (Print Name)	Signature		Date

Section 5 Evaluation for Signs and Symptoms (Complete for all individuals.)

☐ No Symptoms	Symptoms (Check all that apply)		
	☐ Persistent Cough (>2 Weeks)	☐ Unexplained Fever	☐ Unexplained Night Sweats
	☐ Unexplained Weight Loss	☐ Unexplained Fatigue	☐ Other: _____

Section 6 Chest X-Ray (Complete for all positive TB test results, as required by the CDC.)

Chest X-ray Report	Chest X-Ray Results
☐ On File	☐ Normal
☐ Copy Attached	☐ Abnormal
☐ Chest X-Ray Needed	☐ Consistent with TB

Section 7 Evaluation

☐ Employee Referred for Follow-Up Medical Evaluation ☐ Employee Provided Written Notification of TB Screening Results

Comments:

☐ **EMPLOYEE IS FREE OF INFECTIOUS TUBERCULOSIS**

Licensed Evaluator (Print Name)	License Number	Licensed Evaluator Signature	Date

DISTRIBUTION **Original:** Business Information System

ADA Accessible

EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION

CDCR 7336 (Rev. 03/20)

The California Penal Code, Section 6006 et seq., requires all California Department of Corrections and Rehabilitation (CDCR) employees and certain other individuals to have an initial, annual, and as medically necessary, Mantoux Tuberculin Skin Test (TST) or evaluation. The testing must occur as instructed below. The employee must provide the results of the TST or Tuberculosis (TB) blood test and evaluation on the required Employee Tuberculin Skin Test (TST) and Evaluation (CDCR 7336) form.

Definitions:

- **Induration:** Swelling or raised skin. **Note:** The presence of erythema is NOT indicative of a TST reaction; only the induration is measured.
- **Mantoux TST:** Intradermal injection of 0.1 milliliters (ml) of Purified Protein Derivative, 5 Tuberculin Units (TU).
- **Prior TST:** A Mantoux TST in which clearly documented and dated results are available in millimeters (mm).
- **Negative TST Result:** Induration of less than (<) 10 mm if new, or < 5 mm, if contact or known immunocompromised.
- **Positive TST Result:** Induration equal to or greater than (>) 10 mm, OR > 5 mm if contact or known immunocompromised.

CDCR Health Care Providers (HCP) shall not ask CDCR employees about non-TB health history, including immunosuppressive conditions**.**

The Centers for Disease Control and Prevention (CDC) and the California Tuberculosis Controllers Association recommend the following:

1. The tine test is NOT an acceptable skin test to determine exposure to the TB bacillus. The only acceptable screening methods for detecting TB infection are TB screening tests that are licensed by the Federal Food and Drug Administration (FDA) and recommended by the CDC.
2. A chest X-ray (CXR) cannot be used to definitively diagnose TB. However, a CXR may be used to rule out the possibility of pulmonary TB in a person who has had a positive reaction to a TST or TB blood test and no symptoms of disease.
3. The process for administering, evaluation, and documenting the Mantoux TST are:
   a) Must be given intradermally.
   b) 0.1 ml (s) of 5 TU Purified Protein Derivative must be used.
   c) The test must be interpreted by a qualified HCP.
   d) Results must be documented in mm(s) of induration.

Instructions: Employee

Section 1: Complete all items in Section 1.

- Provide accurate and complete information.
- Ensure the health care provider(s) (HCP) administering and evaluating the TST, including the exam for TB signs and symptoms, completes, signs, and dates the form.
- Advise the HCP to follow the steps below when completing Sections 2 through 7.
- If a CXR is needed, you are required to submit a copy of the CXR report with this form for clearance to be placed in your health record.
- Submit the completed Employee Tuberculin Skin Test (TST) and Evaluation (CDCR 7336) form, in a sealed envelope.

Instructions: Health Care Provider (HCP)

Section 2: Complete Section 2, if applicable.

Complete this section if prior TST or TB blood test results and treatment are available. The employee or HCP must provide written documentation including the date test was administered, reaction in mm or IGRA, treatment, and drug administered (if any) start and stop dates.

If documented results are:

- NEGATIVE and more than 30 days old, proceed to Section 3.
- NEGATIVE and less than 30 days old, proceed to Section 5.
- POSITIVE on any date, complete Sections 5, 6, and 7.

If there are no appropriately documented prior TST or TB blood test results, continue to Section 3.

Section 3: Administer a new TST and document the test results in Section 3. The HCP administering the TST in Section 3 must sign and date the appropriate blocks. The block identified as “Date and Time of Results” refers to date the employee’s TB status is determined.

If documented results are:

- NEGATIVE, complete Sections 5 and 7.
- POSITIVE, complete Sections 5, 6, and 7. A copy of CXR report must be attached for all POSITIVE results.

Section 4: Administer a new TB blood test and document the test results in Section 4. The HCP administering the TB blood test must sign and date the appropriate blocks. The block identified as “Date and Time of Results” refers to date the employee’s TB status is determined.

If documented results are:

- NEGATIVE, complete Sections 5 and 7.
- POSITIVE, complete Sections 5, 6, and 7. A copy of CXR report must be attached for all POSITIVE results.

If an individual claims to have a prior positive TB blood test or TST, but is unable to provide appropriate documentation, a TST or TB blood test must still be administered. This is not medically contraindicated. However, a diluted TST may be administered by the following method: dilute 0.2 cc of the standard 5 TU/0.1cc solution with 0.8 cc of sterile saline; use 0.1 of the solution to administer the TST. **Note:** This is not a CDCR procedure. If the results are positive, no further testing is necessary. If the administered or documented TB blood test shows a negative result, the employee most likely does not have the TB infection. Factors affecting the immune system, pregnancy, or recent TB infection may cause a false negative TST or TB blood test reaction, even when TB disease exists. If the TB blood test or TST indicates a positive reaction, further medical evaluation and a CXR are required to rule out active TB disease.

Section 5: Complete the evaluation for all employees. Three or more symptoms warrant special concern.

Section 6: Complete this section for individuals with a prior documented or newly significant TST or TB blood test. If a prior CXR report is on file, attach a copy of the CXR report to this form and mark the applicable results. If the individual does not have CXR report on file, administer a CXR, attach a copy of the report, and check the applicable results. The CXR report is required by CDC.

Section 7: The HCP, Physician, Surgeon or licensed designee evaluating for TB signs and symptoms must compete this section. Evaluators may note comments, as necessary. Check the box if the employee is free of infectious TB, print name, enter license number, sign, and date this section.

After evaluation or treatment, provide the original completed and signed CDCR 7336 form to the employee for return to CDCR.

TB INFECTIOUS FREE STAFF CERTIFICATION

Applicants, current employees, volunteers and employees from other state agencies who work in the California Department of Corrections and Rehabilitation (CDCR) facilities or with CDCR inmates (as defined in Penal Code Section 6006 et seq.) are required to be evaluated for tuberculosis (TB) and certified to be free of TB in an infectious or contagious stage prior to assuming duties with CDCR, and at least annually thereafter. Evaluation shall be done by a licensed physician and surgeon or his/her licensed designee whose legally authorized scope of practice he allows him/her to conduct examinations for TB under physician supervision; in accordance with the most current recommendations of the Centers for Disease Control and Prevention. Certificates shall be submitted to and maintained by CDCR.

CERTIFIED TO BE FREE OF INFECTIOUS TB

PATIENT FULL NAME AS IT APPEARS ON STATE PAYCHECK (*TYPE OR PRINT CLEARLY)*	BIRTHDATE (FOR IDENTIFICATION PURPOSES ONLY)

I,_____ , a physician and
PRINT OR TYPE PHYSICIAN NAME AND TITLE

surgeon licensed by the Medical Board or Osteopathic Medical Board of California, or my licensed designee, have *evaluated the patient, identified above, and ***CERTIFY*** he/she is free of tuberculosis in an infectious or contagious stage.

(* IF EVALUATION INCLUDES A TB SKIN TEST [PREFERRED, AND REQUIRED IF NEITHER **WRITTEN MM OR BLOOD TEST DOCUMENTATION** OF A PRIOR POSITIVE NOR CURRENT TB BLOOD TEST RESULTS], THE MANTOUX INTRADERMAL METHOD WITH A STANDARD DOSE OF PURIFIED PROTEIN DERIVATIVE MUST BE USED.)

LICENSED EVALUATOR OR PHYSICIAN SIGNATURE (AS APPROPRIATE)	DATE	TELEPHONE NUMBER
	LICENSED EVALUATOR NAME AND TITLE IF DIFFERENT FROM ABOVE *(PRINT)*	
LICENSE #	ADDRESS	

NOTICE TO PHYSICIANS

CONFIDENTIAL EMPLOYMENT MEDICAL INFORMATION

DEFINITIONS:

PHYSICIAN AND SURGEON: An individual licensed by either the Medical Board of California or the Osteopathic Medical Board of California.

LICENSED DESIGNEE: An individual who the physician and surgeon designates to conduct the required examination in his/her place, and whose legally authorized scope of practice allows him/her to conduct examinations for TB under physician supervision.

INSTRUCTIONS: EMPLOYEE

Complete the top portion of the form; clearly print your legal name and BIRTHDATE (FOR THE IDENTIFICATION PURPOSE ONLY).

INSTRUCTION: HEALTHCARE PROVIDER

After completing the required examination (as directed on the back of the CDCR Form 7336 "Employee TST and Evaluation"), and completing and signing that form;

- Print the name and title of the supervising physician where indicated.
- The physician or designated evaluator (whoever completes the examination) should sign in the appropriate box. If a designated evaluator, complete the boxes "Evaluator Name and Title, License #"
- Date the form; complete the boxes for the telephone number and address.

STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS AND REHABILITATION

CERTIFICATION OF VOLUNTEER PARTICIPATION

CDCR 1049 (Rev. 08/08)

To be completed by the volunteer's supervisor/sponsor at completion of the volunteer service agreement or termination.

Please Print

Volunteer Name:		Supervisor/Sponsor Name:	
Address:		Institution/Headquarters/Parole Unit:	
		Telephone Number:	Unit/Division:
Telephone Number (Home):	Telephone Number (Work):	Area Where Volunteer Provided Service:	

Describe duties performed: special skills/credentials held, equipment or tools used.

Length of Service: FROM: ____/____/____ TO: ____/____/____

Did the volunteer supervise inmates? Yes ☐ No ☐ If Yes, how many_____

Performance Rating: Excellent ☐ Good ☐ Needs improvement ☐ Unsatisfactory ☐

If dismissed, give reason:

VOLUNTEER'S SIGNATURE | DATE SIGNED | SUPERVISOR/SPONSOR'S SIGNATURE | DATE SIGNED

DISTRIBUTION: ORIGINAL - Volunteer; CANARY - File; PINK - Supervisor

Clear Form Print Form

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT

CDCR 8019 (06/20)

CANDIDATE/EMPLOYEE INFORMATION

Name (Print First and Last)		Institution/Facility/Program
Check one:		
☐	Applying for a position.	Proposed classification:
☐	Reporting a relationship.	Current classification:
☐	Other:	Current classification:

Department Operations Manual (DOM) Section 33010.25, Nepotism and Fraternization

The Department has established policies to counteract nepotism and fraternization in the workplace.

(a) **Policy**

It is the policy of CDCR to recruit, hire, and assign all employees on the basis of merit and fitness in accordance with civil service statutes, rules, and regulations. This policy is intended to uphold the merit principle of civil service by preventing and prohibiting preferential treatment or bias due to personal relationships. Nepotism is antithetical to a merit-based personnel system and staff shall not use their personal relationships to aid or hinder others in the employment setting. CDCR reserves the right to initiate mandatory reassignments, employee transfer, or take other administrative action to avoid or correct situations where the potential for employment decisions based on nepotism exists.

(b) **Personal Relationship Defined**

For purposes of this section, personal relationships include, but are not limited to, an association with another individual by blood, adoption, foster arrangement, cohabitation, current or previous marriages (including in-laws), registered domestic partnership, or romantic relationships.

(c) **Hiring Authority, Manager, or Supervisor Responsibilities**

The hiring authority, managers, or supervisors must ensure their candidates and employees are aware of the departmental nepotism and fraternization policy, including reporting requirements. The hiring authority, manager, or supervisor shall consider the nepotism and fraternization policy prior to making employment decisions. The hiring authority, manager, or supervisor must inform candidates of the nepotism and fraternization policy at the time of interview. As part of the interview process for any position, regardless of whether the candidate is a current employee, each candidate shall be required to sign a CDCR Form 8019, Nepotism and Fraternization Policy Acknowledgement form to confirm their understanding of this policy. In addition, the hiring authority, manager, or supervisor must take appropriate action to correct violations of this policy. The hiring authority, manager, or supervisor is responsible for requesting an exception/appeal to the policy if necessary (refer to Exception/ Appeal Procedures below). Exceptions/appeals to the policy may be granted under limited circumstances.

(d) **Employee Responsibilities**

(1) Upon hire employees shall complete and submit a CDCR Form 8019 to their hiring authority, manager, or supervisor.

(2) Employees shall immediately notify the hiring authority or their respective supervisor when an employment decision is in conflict with the departmental nepotism and fraternization policy. It is the employee's responsibility to read and adhere to the nepotism and fraternization policy.

(e) **Employment Settings**

(1) Employment settings refer to the working relationships of employees and their supervisors. Employees involved in personal relationships may work in the same program, section, or unit as the person with whom they have a personal relationship, however, in accordance with applicable state employment laws and collective bargaining agreements employment settings shall not exist where an employee would:
(A) Work for the same first-line supervisor as the person with whom they have a personal relationship.
(B) Have a direct (first line supervisor), or indirect (second line supervisor) supervisory relationship as the person with whom they have a personal relationship.
(C) Work under a hiring authority with whom they have a personal relationship, regardless of departmental separation.

(f) **Employment Decisions**

(1) Employment decisions refer to the full array of assessments and actions that involve CDCR and employees and their employment. Employees involved in personal relationships may work in the same program, section, or unit as the person with whom they have a personal relationship, however, employment decisions shall not be made where an employee involved in a personal relationship would:
(A) Audit the work of, or exercise fiscal control over a person with whom they have a personal relationship, regardless of organizational separation.
(B) Hire, promote, transfer, or approve an out-of-class, or re-assignment of a person with whom they have a personal relationship.
(C) Participate in the selection process, including assisting with the development of screening criteria and/or interview questions, or serve on a hiring panel of a person with whom they have a personal relationship.
(D) Develop, administer, or rate a civil service examination of a person with whom they have a personal relationship.
(E) Initiate an administrative investigation or be involved in the discipline process of a person with whom they have a personal relationship.
(F) Assign work to a person with whom they have a personal relationship, except in a rare emergency situation.
(G) Prepare, conduct, or contribute information on a performance appraisal of a person with whom they have a personal relationship.
(H) Approve overtime or any other compensated time/pay of a person with whom they have a personal relationship, when it is on a voluntary basis and another supervisor is available.
(I) Approve vacation, sick, or any other type of leave of a person with whom they have a personal relationship, when another supervisor is available.
(J) Grant or deny permission to attend a conference or other work-related event of a person with whom they have a personal relationship.
(K) Approve reimbursement for work related expenses of a person with whom they have a personal relationship.
(L) Adversely affect or influence the safety, security, or morale of employees of a program, section, or unit.
(M) Adversely affect or influence the fair and impartial supervision and evaluation of employees.

(g) **Exception/Appeal Procedures**

(1) When the employment setting or employment decision violates the departmental nepotism and fraternization policy, the hiring authority, manager, or supervisor shall request and receive approval prior to making an employment decision. Actions to remediate noncompliance may include an involuntary transfer of employees, in accordance with applicable state employment laws and collective bargaining agreements. Under no circumstances should an employee participate in the defined employment decisions with an employee, applicant, or candidate with whom they have a personal relationship.
(2) The exception/appeal procedures are as follows:
(A) A written request shall be submitted through the immediate manager or supervisor to the hiring authority, which clearly defines the personal relationship, and the benefit(s) to the State that an exception/appeal would provide (e.g., overcoming a recruitment difficulty or obtaining a uniquely skilled person).
1. For CDCR: Exception/appeal requests involving the hiring authority (Regional Administrator, Deputy Director, Superintendent, etc.) shall be submitted to the next higher level within the hiring authority's chain of command or equivalent, and then to the applicable second higher level within the hiring authority's chain of command or equivalent to render a decision.
2. For CDCR: Exception/appeal requests involving the Warden shall be submitted to the applicable Associate Director or equivalent, then to the applicable Deputy Director or equivalent, and then to the applicable Director or equivalent to render a decision.

3. For CCHCS: Exception/appeal requests involving the hiring authority shall be submitted to the next level within the hiring authority's chain of command. All exception/appeal requests shall be reviewed by the CCHCS Office of Legal Affairs via the Deputy Director, Human Resources, to render a decision.

(B) Each exception/appeal request shall be reviewed to assess the potential for, and degree of impact upon the following:
1. Safety, security, and morale of the employees in the program, section, or unit.
2. Fair and impartial supervision and evaluation of the employee by the supervisor in the program, section, or unit.
3. Basis of merit and fitness in accordance with civil service statutes, rules, and regulations.

(C) A written response to the exception/appeal request will be completed within ten (10) working days.
1. If the exception/appeal request is approved, a copy of the approved document(s) shall be forwarded to the appropriate personnel officer. The personnel officer shall place a copy of the approval document(s) in the hiring and recruitment package and in the respective employee's official personnel file.
2. If an exception/appeal is granted, there shall not be any employment decisions made by the related employees. Another manager or supervisor shall be responsible for employment decisions except in an extremely rare documented circumstance.
3. If the exception/appeal request is denied, a written explanation of the basis for the denial, shall be provided to the candidate or employee. A copy of the denial document(s) shall be forwarded to the appropriate personnel officer. The personnel officer shall place a copy of the denial document(s) in the hiring and recruitment package, and if applicable, into the respective employee official personnel file. Every effort shall be made to avoid relocation expenses. If an employee must relocate to meet the Department's nepotism and fraternization policy, the Department shall pay any associated relocation expenses. (Refer to the CalHR Rules and Regulations.)

(h) **Retention**

All Nepotism and Fraternization forms, and any exception/appeal approvals or denials, shall be forwarded to the personnel officer for filing in either the official personnel file or the hiring and recruitment file.

CANDIDATE/EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have read and understand the nepotism and fraternization policy as stated in DOM Section 33010.25, Nepotism and Fraternization.

Check one:

☐ I do not have any relative(s) or person(s) with whom I have a personal relationship employed by CDCR.

☐ I have the following relative(s) or person(s) with whom I have a personal relationship employed by CDCR. **If checked, complete the information below. Use the back of this form if additional space is needed.**

Name	Relationship	Institution/Program/Section/Unit	Classification
1.			
2.			
3.			
Signature		Date	

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT
CDCR 8019 (06/20)

HIRING AUTHORITY, MANAGER, OR SUPERVISOR INFORMATION

Name (Print First and Last)	Classification
Review DOM Section 33010.25 to determine whether the personal relationship(s) listed above are in conflict with the nepotism and fraternization policy. Check one:	
☐ No conflict.	
☐ Conflict: Relationship #1: ☐ Relationship #2: ☐ Relationship #3: ☐ All Relationships: ☐ **Submit this form with a written request for exception/appeal to the hiring authority or designee.**	
Signature	Date

HIRING AUTHORITY OR DESIGNEE INFORMATION

Name (Print First and Last)	Classification
Review DOM Section 33010.25 to determine whether an exception/appeal to the nepotism and fraternization policy is approved or denied. Check one:	
☐ Exception/appeal approved.	
☐ Exception/appeal denied. State the reason for denial:	
Signature	Date

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART A
CDCR 2301 (Rev. 05/20)

The Prison Rape Elimination Policy for the California Department of Corrections and Rehabilitation (CDCR) is explained on this informational sheet. As a volunteer or private contractor who has contact with CDCR offenders, it is your responsibility to do what you can, within the parameters of your current assignment, to reduce incidents of sexual violence, staff sexual misconduct, and sexual harassment and to report information appropriately when they are reported to you or when you observe such an incident. For purposes of this Policy, the word “staff” includes volunteers and private contractors.

Historical Information

Both the Congress and State Legislature passed laws, the Federal Prison Rape Elimination Act (PREA) of 2003, the Sexual Abuse in Detention Elimination Act, Chapter 303, Statutes of 2005, and most recently the United States, Department of Justice Final Rule; National Standards of 2012 to help prevent, detect, and respond to sexual violence, staff sexual misconduct, and sexual harassment behind bars. It is important that we, as professionals, understand all aspects of these laws and our responsibilities to help prevent, detect, and respond to instances by offenders and staff.

CDCR Policy

The CDCR policy is found in Department Operations Manual (DOM), Chapter 5, Article 44. PREA addresses five types of sexual offenses. Sexual violence committed by offenders against offenders encompasses: abusive sexual contact, non-consensual sex acts, and sexual harassment by an offender. Other sections covered by PREA include staff sexual misconduct towards an offender and staff sexual harassment towards an offender.

CDCR’s policy provides for the following:

- CDCR is committed to continuing to provide a safe, humane, secure environment, free from offender on offender sexual violence, staff sexual misconduct, and sexual harassment.
- CDCR maintains zero tolerance for sexual violence, staff sexual misconduct, and sexual harassment in its institutions, community correctional facilities, conservation camps, and for all offenders under its jurisdiction.
- All sexual violence, staff sexual misconduct, and sexual harassment is strictly prohibited.
- This policy applies to all offenders and persons employed by the CDCR, including volunteers and independent contractors assigned to an institution, community correctional facility, conservation camp, or parole.

Retaliatory measures against employees or offenders who report incidents of sexual violence, staff sexual misconduct, or sexual harassment as well as retaliatory measures taken against those who cooperate with investigations shall not be tolerated and shall result in disciplinary action and/or criminal prosecution. Retaliatory measures include, but are not limited to:

- Coersion.
- Threats of punishments.
- Any other activities intended to discourage or prevent staff or offenders from reporting incident(s).

Professional Behavior

Staff, including volunteers and private contractors are expected to act in a professional manner while on the grounds of a CDCR institution and while interacting with other staff and offenders. Key elements of professional behavior include:

- Treating everyone, staff and offenders alike, with respect.
- Speaking without judging, blaming, or being demeaning.
- Listening to others with an objective ear and trying to understand their point of view.
- Avoiding gossip, name calling, and what may be perceived as offensive or "off-color" humor.
- Taking responsibility for your own behavior.

Preventative Measures

You can help reduce sexual violence, staff sexual misconduct, and sexual harassment by taking various actions during the performance of your duties as a volunteer or private contractor.

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART A
CDCR 2301 (Rev. 05/20)

The following are ways in which you can help:

- Know and enforce the rules regarding the sexual conduct of offenders.
- Be professional at all times.
- Make it clear that sexual activity is not acceptable.
- Treat any suggestion or allegation of sexual violence, staff sexual misconduct, and sexual harassment as serious.
- Follow appropriate reporting procedures and assure that the alleged victim is separated from the alleged predator.
- Never advise an offender to use force to repel sexual advances.

Detection

All staff, including volunteers and private contractors, is responsible for reporting immediately and confidentially to the appropriate supervisor any information that indicates an offender is being, or has been, the victim of sexual violence, staff sexual misconduct, or sexual harassment.

After immediately reporting to the appropriate supervisor, you are required to document the information you reported. You will be instructed by the supervisor regarding the appropriate form to be used for documentation.

You will take necessary action (i.e., give direction or press your alarm) to prevent further harm to the victim. Staff, including volunteers and private contractors, will request the victim does not: 1) Shower; 2) Remove clothing without custody supervision; 3) Use the restroom facilities; and 4) Consume any liquids.

I have read the information above and understand my responsibility to immediately report any information that indicates an offender is being, or has been, the victim of sexual violence, staff sexual misconduct, or sexual harassment.

Volunteer/Contractor Name (Printed)	Date Signed
Signature of Volunteer/Contractor	Current Assignment within Institution
Contact Telephone Number	Supervisor in Current Assignment

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART B
CDCR 2301 (Rev. 05/20)

PART B shall only be completed by contractors who, in the course of their assigned duties, have contact with inmates.

Duty to Report

You are required to answer the following questions:

1) Have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, other institution?
☐ Yes ☐ No If yes, provide the date of the incident and the facility name in the space below.

2) Have you ever been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?
☐ Yes ☐ No If yes, provide the date of the incident and the county in the space below.

3) Have you ever been civilly or administratively found to have engaged in the activity described in question (2) above?
☐ Yes ☐ No If yes, provide the date of the incident and the county in the space below.

4) Have you ever received any disciplinary action as a result of allegations of sexual harassment of an inmate in a prison, jail, lockup, community confinement facility, or other institution?
☐ Yes ☐ No If yes, provide the date of the incident and the facility name in the space below.

If you answered "Yes" to any of the questions, please provide the date of the incident and the facility name/county where it occurred:

Date:_____ Facility/County Name:_____

As a contract employee, you have a continuing duty to promptly report, and you are required to notify your employer and the Appointing Authority of the Institution to which you are assigned if the answer to any of the above questions changes.

I hereby certify that there are no misrepresentations, omissions, or falsifications, and that all answers are true and correct. I understand and agree that if any material facts are discovered which differ from those facts stated by me on this form, my services to the California Department of Corrections and Rehabilitation will be discontinued and my contract employer will be notified.

Printed Name:	
Signature:	Date:

STD. 910 (EST. 1/2002) (FRONT)

ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

APPLICANT INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE
ADDRESS		CITY	STATE / ZIP CODE
DAYTIME TELEPHONE / EVENING TELEPHONE	CLASSIFICATION	HIRING DEPARTMENT	

CONTACT INFORMATION

NAME	TITLE
LOCATION	TELEPHONE

LIST OF ESSENTIAL FUNCTIONS

Enter list of essential functions of the job from current duty statement here, or attach duty statement:

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by a volunteer to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Standing: Frequently - stands while speaking with inmates, staff, and other volunteers.
Walking: Occasionally - walks to and from parking area, to gate, to the various facilities to perform services/programs.
Sitting: Frequently - sits during programs. There is flexibility for movement on a frequent basis to break sitting with standing and walking.
Lifting: Occasionally - occasionally lift paperwork/files/materials for program/service.
Carrying: Occasionally - carries paperwork, files and materials for short distances.
Bending/Stooping: Occasionally - bending/stooping occurs when picking up paperwork/files/materials and loading/unloading them from vehicles. Slight bending at the waist and neck occurs on a frequent basis throughout the day.
Reaching in Front of Body: Frequently - placing items on and retrieving items from waist/shoulder level tables.
Climbing: Occasionally - climbs steps throughout the institution in order to get to program space.
Pushing/Pulling: Occasionally may push and pull on binders, equipment, supplies, books as needed.

ACKNOWLEDGEMENT

I certify that the duties listed above represent the essential functions of the job and classification listed above.

SUPERVISOR'S NAME	SUPERVISOR'S SIGNATURE	DATE
PERSONNEL OFFICER'S NAME	PERSONNEL OFFICER'S SIGNATURE	DATE

APPLICANT'S CERTIFICATION OF ESSENTIAL FUNCTIONS

I certify that I have read the essential functions of the job listed on page 1 and considering my current health status (please check one of the boxes below):

- ☐ I am able to perform all of the essential functions of the job without a need for reasonable accommodation.
- ☐ I am able to perform all of the essential functions of the job, but will require reasonable accommodation (please describe your requested accommodation in the Reasonable Accommodation section below).
- ☐ I am unable to perform one or more of the essential functions of the job, even with reasonable accommodation.
- ☐ I am not sure if I am able to perform one or more of the essential functions of the job. I have identified the functional limitations that I believe may limit my ability to perform the essential functions of the job in the Request for Essential Functions Evaluation section below.

REASONABLE ACCOMMODATION (If necessary, you may attach additional pages)

For each essential function of the job for which you require reasonable accommodation, please describe the reasonable accommodation you are requesting:

REQUEST FOR ESSENTIAL FUNCTIONS EVALUATION (If necessary, you may attach additional pages)

I am not sure whether I have a physical or mental limitation that may prevent or otherwise impair me from performing the essential functions of the job. Below I have listed the essential functions in question and my specific functional limitations that I believe may prevent or otherwise impair me from performing the listed essential functions of the job. I authorize the hiring authority, if necessary, to refer this information to the State Personnel Board's Medical Officer, or his/her delegate, to determine my ability to perform the essential functions of the job with or without reasonable accommodation.

ACKNOWLEDGEMENT

I certify that the information I have provided concerning my ability to perform the essential functions of the job is true and complete to the best of my knowledge.

APPLICANT' S NAME *(Print or type)*	APPLICANT'S SIGNATURE	DATE

STATE OF CALIFORNIA
PARENT CONSENT FOR PARTICIPATION
CDCR 1887 (REV. 08/08)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Volunteer minors under the age of eighteen shall have an approved Parent Consent For Participation form on file prior to entering any institution, facility, or camp. Volunteer minors shall be supervised by parent(s)/guardian(s) at all times while on State property.

Please Print
Parent(s) or Guardian(s) child/children live(s) with:

If parents are divorced or separated, to whom has physical custody been granted? (Attach verification)

Father: _____ Check One: ☐ Natural ☐ Step ☐ Guardian/Foster
Home Phone: _____ Business Phone: _____
Mother: _____ Check One: ☐ Natural ☐ Step ☐ Guardian/Foster
Home Phone: _____ Business Phone: _____

Please Print
Name of Minor: _____ Age: _____ ☐ Male ☐ Female Date(s) of Participation: _____
Name of Minor: _____ Age: _____ ☐ Male ☐ Female Date(s) of Participation: _____
Name of Minor: _____ Age: _____ ☐ Male ☐ Female Date(s) of Participation: _____

I/We the parent(s)/guardian(s) of the minor(s) listed above do hereby give permission for my/our child/children to participate in the scheduled California Department of Corrections and Rehabilitation (CDCR) program or event. Furthermore, I/we understand the institution, facilicy, or camp may house convicted maximum security felons, and that CDCR does not recognize hostages for bargaining purposes. I/We hereby certify and acknowledge I/we have read the above and fully understand the significance of the information and attachments provided. Furthermore, I/we shall not hold CDCR responsible for any mishap which may occur while my/our child/children participate in this program or event.

_____ _____ _____ _____
PARENT/GUARDIAN SIGNATURE DATE PARENT/GUARDIAN SIGNATURE DATE

Please Print
Name of Supervisor/Sponsor: _____ Title: _____ Location: _____

Telephone Number: _____ Unit/Division: _____ Work Hours: _____

CERTIFICATE OF ACKNOWLEDGEMENT

State of California)
County of _____)

On _____ before me, _____, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacit(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

(Notary Seal)

Signature _____

DISTRIBUTION: ORIGINAL - File; CANARY - Supervisor; PINK - Parent/Guardian