



VOLUNTEER APPLICATION FORM

1110 West Capitol Ave., West Sacramento, CA 95691

Office: (916) 617-4620 FAX: (916) 372-5329 Email: parks@cityofwestsacramento.org

Thank you for taking the time to complete this application. We look forward to working with you and appreciate your generous offer to share your time and talents with our community. Please type or print clearly. Applicants must be at least 13 years of age. **If interested in only 8 hours of community service, please refer to the Community Service Application.**

Date: _____		Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>	Dr. <input type="checkbox"/>
Last Name: _____		First Name: _____			
Male <input type="checkbox"/> Female <input type="checkbox"/>		Age: _____			
Home Address: _____		City: _____			
Zip: _____	Home Phone: _____	Cell/Work Phone: _____			
Email Address: _____					

Please check the area(s) you would like to volunteer in:	
<input type="checkbox"/> Coaching: Specify sport _____ Child's name/age (if applicable) _____	
<input type="checkbox"/> Assistant Coach	<input type="checkbox"/> City Pride/Beautification
<input type="checkbox"/> Special Olympics/Special Populations	<input type="checkbox"/> Teen Heroes (ages 13 to 15 only)
<input type="checkbox"/> Special Events/Event Planning	<input type="checkbox"/> Volunteer Program Coordination
<input type="checkbox"/> Tree Planting/Tree Care	<input type="checkbox"/> Senior Services/Senior Center
<input type="checkbox"/> Office Support	<input type="checkbox"/> Other: _____
<input type="checkbox"/> I am a Returning Volunteer. Last year I volunteered: _____	

Languages Spoken/Familiar with: _____

Do you have any of the following certifications: CPR _____ First Aid _____

How did you hear about volunteering with the West Sacramento Parks & Recreation Department?

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR OTHER THAN MINOR TRAFFIC VIOLATIONS? YES NO

If yes, please provide details on a separate sheet of paper and submit with your application. NOTE: CONVICTIONS ARE EVALUATED FOR EACH POSITION AND ARE NOT NECESSARILY DISQUALIFYING. DRUNK, RECKLESS OR HIT-RUN DRIVING ARE NOT MINOR VIOLATIONS. The California Fair Employment and Housing Commission also prohibits asking applicants about convictions that have been sealed, expunged or legally eradicated, or misdemeanor convictions for which probation was completed and the case was dismissed.

FOR OFFICE USE ONLY		
<input type="checkbox"/> New	<input type="checkbox"/> Returning	<input type="checkbox"/> Fingerprint Clearance
<input type="checkbox"/> Background Clearance		<input type="checkbox"/> TLC Training
<input type="checkbox"/> Entered in Database		<input type="checkbox"/> Program Specific Training
<input type="checkbox"/> CPR	<input type="checkbox"/> First Aid	

Application Continued on Reverse Side

By submitting this application, I, _____, affirm that the facts set forth are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in either the denial of my application or my immediate dismissal. **I further agree participate in a comprehensive background check (at the city's expense)*.**

I, _____, authorize and give consent for The City of West Sacramento to obtain information regarding myself. This includes the following:

- Criminal background records/information
- Sex Offender Registry Checks
- Addresses

I the undersigned, authorize this information to be obtained either in writing or via telephone in connection with my volunteer application. Any person, firm or organization providing information or records in accordance with this authorization is released from any and all claims of liability for compliance. Such information will be held in confidence in accordance with the organization's guidelines.

Volunteer Applicant Name (Print) _____

Volunteer Applicant Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____
(if volunteer is under 18 years of age)

Parent/Guardian's Phone _____ Email _____

It is the intent of the West Sacramento Parks & Recreation Department to provide equal opportunity to all volunteers in all terms, privileges and conditions without regard to sex, race, religion, national origin, disability or any other factor.

**City of West Sacramento
Parks & Recreation**

VOLUNTEER AGREEMENT RELEASE

I, _____ (name), agree to perform to the best of my abilities, the volunteer activity (hereinafter referred to as the Activity) outlined in this form below. I understand that as a volunteer, authorized by the City of West Sacramento, there may be certain risks associated with this Activity. Therefore, I hereby state and affirm that:

- 1) To the best of my knowledge, I am physically and mentally fit to undertake the Activity outlined herein. If at any time while I am engaging in the Activity, it becomes reasonably apparent that I am no longer mentally or physically fit to continue engaging in the Activity, I will immediately cease any and all activity.
- 2) In consideration for being permitted to take part in this Activity on property of the City of West Sacramento. I do so hereby release, waive, discharge and covenant not to sue the City of West Sacramento, its officers, employees, and agents, regarding any harm or injury of any nature that I may incur as a result of participating in the Activity, including, without limitations, for negligent actions or omissions. I understand that there may be both foreseen and unforeseen risks associated with the activity and I assume all the risks associated. Therewith I do hereby indemnify and save and hold harmless the City of West Sacramento, its officers, employees, and agents, from any and all liability actions, causes of actions debts, claims and demands of every kind and nature whatsoever which may arise during the course or as a result of my participation in the Activity.
- 3) By way of this form, I authorize the City of West Sacramento staff to assist me by administering basic first aid or appropriate emergency medical treatment for me in the event of an accident, injury, or illness as the circumstances warrant.
- 4) Unless I indicate otherwise in writing herein, I hereby give my consent for photographs, videotapes, or audiotapes to be taken of me during the course of the Activity for use by the City of West Sacramento for publicity purposes. My first name is the only personal information about me that may be released by the City of West Sacramento in the use of the above-mentioned media.
- 5) I agree that the terms of this Agreement shall be binding on my heirs, executor, administrator and all members of my family.
- 6) By signing this Agreement, I am certifying that I have read and understand the safety guidelines contained in the training materials as well as the rules and hereby agree to comply with their professions. I am also indicating my agreement to all the terms and conditions contained herein.
- 7) I understand that the above Activity may be of a hazardous nature and/or strenuous exercise or activity; that serious accidents occasionally occur during the above activity (such as falls, slips, cuts and bruises, and may be at risk of death for this particular Activity); that participants in the above Activity occasionally sustain mortal or personal injuries and/or property damages as a consequence thereof. Knowing the risks involved, nevertheless, I have voluntarily applied to participate in said activity and I hereby agree to assume any and all risks of injury or death and to release and hold harmless the above City (its officers, employees, or agents) who through negligence, carelessness, or any other act or omission might otherwise be liable to me.

I agree to accept the following volunteer assignment:

Program event _____

Location and Supervisor's Name _____

Days/Hours _____

Beginning Date _____ Length of Commitment _____

Emergency Contact Name, Address, and Phone Number _____

Volunteer Name (PRINT) _____ Date _____

Volunteer Signature _____

Parent/Guardian Signature (If under age 18) _____ Date _____

SEE REVERSE SIDE

Volunteer Supervisor Signature _____ Date _____

EMERGENCY MEDICAL FORM

Name _____ Date of Birth _____

Phone _____ Alternate Phone _____

Address _____

E-mail _____

Health Insurance Provider _____

EMERGENCY CONTACT WHO CAN AUTHORIZE MEDICAL TREATMENT

Name _____ Date of Birth _____

Phone _____ Alternate Phone _____

Address _____

Relationship _____

LOCAL EMERGENCY CONTACT

Name _____ Date of Birth _____

Phone _____ Alternate Phone _____

Address _____

Relationship _____

ADDITIONAL INFORMATION

Do you wear glasses or contacts? _____ Do you smoke? _____

Do you regularly take any medication? _____

Do you have any allergies? _____

Any other special conditions (use back if you need extra space) _____



**City of West Sacramento
Parks & Recreation**

VOLUNTEER EMERGENCY AUTHORIZATION FORM

I, _____
(Volunteer or Parent or Guardian of Minor Volunteer)

Parent/Guardian of _____,

born on *(Insert Date)* _____, do hereby give my consent to the City of West Sacramento Parks & Recreation Department, to secure and authorize such emergency medical treatment as the above name might require while under the supervision of said care provider. I also agree to pay all the costs and fees contingent on emergency medical care or treatment for this person as secured or authorized under this consent. NOTE: Every effort will be made to notify the parents/ son/ daughter/ guardian, etc. in case of an emergency in the event of an emergency. It would be necessary to have the following information:

Physician's Name _____ Phone Number _____

Address _____

Volunteer Signature _____

Date _____

Parent/Guardian Signature *(If under age 18)* _____

Date _____





**CITY OF WEST SACRAMENTO
PARKS & RECREATION**

Consent/Release Form

Applicant's Name (printed) _____

Social Security Number _____ Date of Birth _____

Applicant's Address _____

City _____ State _____ Zip _____

I, _____, authorize and give consent for the above named _____ organization to obtain information regarding myself. This includes the following:

- Criminal background records/information
- Sex Offender Registry Checks
- Addresses

I the undersigned, authorize this information to be obtained either in writing or via telephone in connection with my volunteer application. Any person, firm or organization providing information or records in accordance with this authorization is released from any and all claims of liability for compliance. Such information will be held in confidence in accordance with the organization's guidelines.

Print Name: _____ Date: _____

Signature: _____





YCPARMIA Medical Provider Network
Employee Acknowledgement of Receipt

This acknowledgement of receipt is for record keeping purposes only and will be kept in your personnel file to confirm you received and understand this notice. Your signature is not mandatory but we advise you acknowledge receipt of the MPN written notification letter. Please sign this receipt and return it to your HR Department.

I, _____, have read and understand the Medical Provider Network
Name (please print)
notification provided to me.

Signed: _____ Date: _____

**Important Information about Medical Care if you have a
Work-Related Injury or Illness**

Initial Written Employee Notification Re: Medical Provider Network
(Title 8, California Code of Regulations, section 9767.12)

California Law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer meets this obligation through its membership in the Yolo County Public Agency Risk Management Insurance Authority (YCPARMIA), which has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). Interplan Health Inc. administers the YCPARMIA MPN, with claims continuing to be handled by Gregory B. Bragg and Associates. This notification tells you what you need to know about the YCPARMIA MPN program and describes your rights in choosing medical care for work related injuries and illnesses.

- **What is an MPN?**

A Medical Provider Network (MPN) is group of health care providers (physicians and other types of providers) set up by an insurer or self-insured employer and approved by the Division of Workers' Compensation's Administrative Director to treat workers injured on the job. Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. MPNs must meet access to care standards for common occupational injuries and work-related illnesses. Further, the regulations require MPN providers to use medical treatment guidelines adopted by the State DWC.

MPNs must allow employees a choice of provider(s) in the network after the employee's first visit.

- **How do I find out which doctors are in my MPN?**

Your employer or insurer has identified the following organization to be the **MPN Contact** for all employees:

Name: Professional Dynamics Inc.
Title: MPN Administrator
Address: PO Box 1090, Rancho Cordova, CA 95741
Phone Number: (800) 591-5501
Email address: mpnadmin@professionaldynamics.com

This organization will be able to answer your questions about the YCPARMIA MPN and tell you how to receive or access the names of the doctors in the MPN. A list of YCPARMIA MPN providers is included with this notification. A list of MPN providers can be obtained by calling our MPN contact person, or going to their website at: www.interplanhealth.com, by asking your employer, or at the YCPARMIA website (www.ycparmia.com) which also provides a link to the list of MPN providers.

- **What happens if I get injured at work?**

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer or insurer that you have had a work-related injury, your employer or insurer will arrange an initial appointment with a doctor in the YCPARMIA MPN. **In case of an emergency, you should call 911 or go to the closest emergency room.**

- **How do I choose a provider?**

After the first visit, you may continue to be treated by this doctor, or you may choose another doctor from the YCPARMIA MPN. You may continue to choose doctors within the YCPARMIA MPN for all of your medical care for this injury. If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. If you need help in choosing a doctor, you may contact the YCPARMIA Wellness Nurse or the MPN Contact listed above. If you have trouble getting an appointment with a doctor within the MPN, contact the MPN Contact who will assist you.

- **What if there are no providers in my area?**

The YCPARMIA MPN has providers for the areas centered on Yolo County. If you are temporarily working outside the YCPARMIA MPN service areas, you may treat with a doctor of your choice. If you are in a situation where a particular specialist is not available in your area, please contact the MPN Contact. You may have the right to see a specialist outside of the MPN in this case.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or do not like your doctor for any reason, you may always choose another doctor within the MPN.

If you disagree with either the **diagnosis or treatment** prescribed by your doctor, you may ask for a second opinion from a doctor within the YCPARMIA MPN. If you want a **second opinion**, you must contact the MPN Contact and tell them you want a second opinion. The contact person will make sure you have a list of MPN doctors to choose from. Then you may choose a doctor from the YCPARMIA MPN and make an appointment within 60 days. You must tell the MPN Contact person of your appointment date. If you do not make an appointment within 60 days, you will not be allowed to have a second opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you will get a new list of YCPARMIA MPN doctors or specialists so you can make another selection.

After you receive a second opinion, if you still disagree with your doctor, you may ask for a third opinion. If you want a **third opinion**, you must contact the MPN Contact and tell them you want a third opinion. They will make sure you have a list of YCPARMIA MPN doctors to choose from. Then you may choose a doctor from the YCPARMIA MPN and make an appointment within 60 days. You must tell the MPN Contact of your appointment date.

If you do not make an appointment within 60 days, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the third opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you will get a new list of YCPARMIA MPN doctors or specialists so you can make another selection.

If after the third opinion, you still disagree with your doctor, you may ask for an **Independent Medical Review (IMR)**. Your employer, through the claims administrator or MPN contact person will give you information on requesting an Independent Medical Review and a form at the time you request a third opinion.

An IMR will be done by a physician, outside of the MPN, who will be selected to conduct an independent assessment of your dispute.

As long as your second opinion, third opinion or Independent Medical Reviewer agrees with the treating doctor, you will need to continue to receive your medical treatment with doctors in the Yolo County Public Agency Risk Management Insurance Authority MPN network.

If the second opinion, third opinion or Independent Medical Reviewer does not agree with your treating doctor, you will be allowed to receive that medical treatment from a provider either inside or outside the YCPARMIA MPN. If you decide to receive treatment outside the MPN, it can only be for the treatment or diagnostic service recommended by the second opinion, third opinion or Independent Medical Reviewer.

Once this treatment is completed, you will receive all other treatment with a doctor of your choice back in the MPN Network.

- **What if I am already being treated for a work-related injury before the YCPARMIA MPN begins? What is “transfer of care”?**

The YCPARMIA MPN has a “**transfer of care**” policy that describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the MPN.

If your current treating doctor is a member of the YCPARMIA MPN, then you may continue to treat with this doctor and your treatment will be under YCPARMIA MPN.

If your current treating doctor is not a member of the YCPARMIA MPN, then you may be sent to a YCPARMIA MPN doctor for treatment. If this occurs, you will be sent a letter and your doctor will also be notified.

You will not be transferred to a doctor in the YCPARMIA MPN if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed within 30 days;
- **(Serious or chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.

If the YCPARMIA MPN is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above.

If either the YCPARMIA MPN or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify the MPN Contact listed previously if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision.

If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved.

- **What if I am being treated by a YCPARMIA MPN doctor and the doctor leaves the MPN?**

The YCPARMIA MPN has a written **Continuity of Care Policy** that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in the YCPARMIA MPN.

If you are being treated for a work-related injury in the YCPARMIA MPN and your doctor no longer has a contract with the MPN, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- **(Acute)** An Acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and or has a limited duration. Completion of treatment shall be provided for the duration of the acute condition.
- **(Serious Chronic)** A serious chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment and to

arrange for a safe transfer to another provider, as determined by the insurer or employer in consultation with the injured employee and the terminated provider and consistent with good professional practice. Completion of treatment under this paragraph shall not exceed 12 months from the contract termination date.

- **(Terminal)** A terminal illness is an incurable or irreversible condition that has a high probability of causing death with one year or less. Completion of treatment shall be provided for the duration of the illness.
- **(Pending Surgery)** Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

If any of the above conditions exist, YCPARMIA MPN may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the YCPARMIA MPN Network. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by YCPARMIA MPN for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor.

- **What if I have questions or need help?**

- **MPN Contact:** You may always contact the MPN Contact if you more help or explanation about your medical treatment if you have a work-related injury or illness.

Name: Professional Dynamics Inc.
Title: MPN Administrator
Address: PO Box 1090, Rancho Cordova, CA 95741
Phone Number: (800) 591-5501
Email address: mpnadmin@professionaldynamics.com

- **MPN website:** www.Interplanhealth.com
- **DWC Information & Assistance Officer:** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call Information and Assistance Officer at the Division of Workers' Compensation at 1-800-736-7401.
- **Independent Medical Review:** If you have questions about the Independent Medical Review process or the Independent Medical Reviewer, you may contact the Division of Workers' Compensation's Medical Unit at:
P.O. Box 8888
San Francisco CA94128-8888
(650) 737-2700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.