MEMORANDUM FOR CAMP ZAMA VOLUNTEER COACH

U.S. Army Child, Youth & School Services

SUBJECT: Volunteer Application Process

Thank you for volunteering to coach the youth/teens in our community. This program depends on people like you stepping up and giving your time. Below is the volunteer process to coach for YSF;

1. Please fill out all forms and make sure to sign where required.
2. Return all documents to our office (Youth Center, BLDG #744).
3. The Coach's checklist must be completed before you are allowed to be a coach.

If you have any questions, please feel free to contact us at the Youth Sports and Fitness Office 263-5437

YOUTH SPORTS AND FITNESS DIRECTOR

ROBERT SANTANA

Attachments;

(1) Coaching Application
(2) Telephonic References (Need Two References)
(3) Volunteer Agreement (DD Form 2793)
(4) Authorization for Disclosure of Medical/Dental Information (DD Form 2870)
(5) ADAPCP Client's Consent Statement for Release of Treatment Information, DA Form 5018-R
(6) Request for Background Information and investigation
(7) Supplemental –A Employment Application Form for CYSS Position (DA Form 3433-2)

U.S. Army Child, Youth & School Services

CHILD, YOUTH and SCHOOL SERVCES COACH'S CHECKLIST

NOTE: THE FOLLOWING REQUIREMENTS ARE MANDATORY FOR ALL INDIVIDUALS REGISTRERING TO BE A HEAD OR ASSISTANT COACH FOR ALL YSF SPORTS.

Check Completed:

_____ **Completed Coach's Application**

_____ **Two Personal References**

_____ **Volunteer Agreement (DD Form 2793)**

_____ **Authorization for Disclosure of Medical or Dental Information (DD form 2870)**

_____ **ADAPCP Client's Statement for Release of Treatment Information (DA Form 5018-R)**

_____ **Request for Background Information and Investigation**

_____ **Supplemental –A Employment Application Form for CYSS Positions (DA Form 3433-2)**

_____ **Required Training – Child Abuse, Touch Policy and Guidance**

_____ **National Youth Sports Coach Association (Coaches Certification)**

Volunteer must be In-line of sight of YSF staff or another certified coach, until all IRC is completed. If you have any questions or concerns, please feel free to call the YSF office at 263-5437.

_____

Print Name

_____ _____

Applicant's Signature Date

U.S. Army Child, Youth & School Services

CYS Japan- Youth Sports
Coaching Application

Name	Rank	Home Phone
Mailing Address Unit#:	Box#	Work Phone
Work E-mail	DOB	Cell Phone
Home E-mail	DEROS	FAX

Please circle the sport you desire to coach. Prioritize within the sport the age group you wish to coach.

Basketball	3-4 5-6 7-8 9-10 11-12 13-15
Baseball	3-4 5-6 7-8 9-10 11-12 13-15
Softball (Girls)	9-11 12-15
Soccer	3-4 5-6 7-8 9-10 11-12 13-15
Flag Football	5-6 7-8 9-10 11-12 13-15
Cheerleading	4-6 7-9 10-15
In-line Hockey	7-10 11-15
Volleyball (Girls)	7-10 11-15
Swimming Team	_Fall (Aug-Dec) _Spring (Jan-Mar)

Head Coach Assistant Coach with----------

How many years have you coached? ____years. Where else have you coached and what sports?

Describe your knowledge in the sport you desire to coach.

Are you planning to coach your child?
(If so, please provide child's information)

Child's Name Age

The final selection of coaches is determined by experience, previous history with youth sports, and available of positions. In accepting a volunteer position in the youth sports program, you agree to abide by the pol'ides set forth by Ch'1ld & Youth Services and understand a background check for child and drug abuse is required. Please complete all forms attached and return toYS Sports Office.

Signature of Applicant Date

U.S. Army Child, Youth & School Services

Telephonic Reference

For Child Youth & School Services' Volunteer Coach

PURPOSE: To provide a character reference for prospective Child Youth & School Services volunteer coach.

DISCLOSURE: Disclosure of requested information is voluntary however, if information is not provided, certification of candidate may be denied.

NAME OF Volunteer Coach (LAST, FIRST, MI):

_____

NAME OF REFERENCE (LAST, FIRST, MI): TELEPHONE NUMBER

_____ _____

NAME OF REFERENCE (LAST, FIRST, MI): TELEPHONE NUMBER

_____ _____

_____

This is to be completed by Youth Sports and Fitness Staff

Outcome (Please Circle One): POSTIVE NEGATIVE

COMMENTS:_____

_____

_____

VOLUNTEER AGREEMENT FOR

☐ APPROPRIATED FUND ACTIVITIES ☐ NONAPPROPRIATED FUND INSTRUMENTALITIES

PART I - GENERAL INFORMATION

1. TYPED NAME OF VOLUNTEER *(Last, First, Middle Initial)*		2. YEAR OF BIRTH
3. INSTALLATION	4. ORGANIZATION/UNIT WHERE SERVICE OCCURS	
5. PROGRAM WHERE SERVICE OCCURS	6. ANTICIPATED DAYS OF WEEK	7. ANTICIPATED HOURS

8. DESCRIPTION OF VOLUNTEER SERVICES

PART II - VOLUNTEER IN APPROPRIATED FUND ACTIVITIES

9. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services, tort claims, the Privacy Act, criminal conflicts of interest, and defense of certain suits arising out of legal malpractice. I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services I will be providing.

a. SIGNATURE OF VOLUNTEER		b. DATE SIGNED *(YYYYMMDD)*
10. a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART III - VOLUNTEER IN NONAPPROPRIATED FUND INSTRUMENTALITIES

11. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services and liability for tort claims as specified in 10 U.S.C. Section 1588(d)(2). I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers, and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services that I am offering.

a. SIGNATURE OF VOLUNTEER		b. DATE SIGNED *(YYYYMMDD)*
12. a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART IV - TO BE COMPLETED AT END OF VOLUNTEER'S SERVICE BY VOLUNTEER SUPERVISOR

13. AMOUNT OF VOLUNTEER TIME DONATED				14. SIGNATURE	15. TERMINATION DATE *(YYYYMMDD)*
a. YEARS *(2,087 hours=1 year)*	b. WEEKS	c. DAYS	d. HOURS		
16. a. TYPED NAME OF SUPERVISOR *(Last, First, Middle Initial)*				b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
ANY	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE The Military Health System TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
Civilian Personnel Advisory Center, Garrison Command and/or CYSS Program Review Board	INSTALLATION:
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [X] OTHER *(Specify)* Employment or volunteer screening
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
Medical and/or mental health information necessary to determine if I have a condition that could impair my judgment, reliability, or fitness for a position requiring routine interaction with children including, if applicable, the nature of the condition, prognosis and dates of treatment. Included, if applicable, is information pertaining to alcohol, drug or prescription drug abuse treatment dates, diagnoses and outcomes.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	[ ] DATE *(YYYYMMDD)* [ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCS, G-1.

SECTION A - CONSENT

I, _____ , this _____ day of _____ 20____ ,
(client's full name)

do hereby voluntarily consent to the release of the following information by Camp Zama - ASAP
(name of installation ADAPCP)

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitatiton, or research to Youth Sports and Fitness

_____ for the purpose of Youth Sports Coach

_____

_____

_____

_____ namely,

Any/All positive results from ASAP Drug & Alcohal Management Information System (DAMIS)
(extent or nature of information to be disclosed)

SECTION B - EXPIRATION/REVOCATION

(Check applicable paragraph)

1. ☐ I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3), AR 600-85)

2. ☐ I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to _____

_____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ADAPCP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS *(Type or print)*	SIGNATURE	DATE

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.

In my judgment, the release of an evaluation of the present or past status of _____
(client's name)

in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE *(Type or print)*	DATE
SIGNATURE	

REQUEST FOR BACKGROUND INFORMATION AND INVESTIGATION

For Child and Youth Services Positions IAW AR 215-3 and AR 608-10

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code 3013 and Executive Order 9397.

PURPOSE: To give permission for agencies to provide necessary clearances by examination of records.

ROUTINE USE: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

DISCLOSURES: Giving your permission for information is voluntary; however, failure to provide information may result in denial of opportunities within Child, Youth and School Services' programs.

1. I understand that Army Regulation (AR) 215-3, Nonappropriated Funds Personnel Policy and AR 608-10, Child Development Services, requires the record screening outlined in paragraph 2 below, and that without favorable completion of these background checks, I may not be eligible for any position involving children and youth.

2. The following Background Checks are required:

   a. CID Records and U.S. Crime Records Center, to include a check of the Defense Central Investigation Index (DCII).

   b. Military Police Records.

   c. Family Advocacy Records

   d. Army Substance Abuse Program (ASAP)

   e. Behavioral Health (Army Central Registry)

   f. School Counselor / References / Housing / Host Nation Law Enforcement / Command as applicable

3. I further understand that the purpose of these background checks is to identify anyone applying for or volunteering for Child, Youth and School Services positions that may have instances of reported misconduct involving children, assaultive behavior, substance abuse, larceny, or other misconduct which would be inconsistent with working with children.

4. I agree that the Child, Youth and School Services office may initiate these checks and receive the resulting information, as required by AR 215-3 and AR 608-10.

TO BE COMPLETED BY SKIES Contractors, HIRED, Volunteer, Youth Coach and FCC Personnel

Full Name	Social Security No.
Maiden Name	Any Other Names Used by Applicant
Place of Birth	DOB

I _____ understand that if any of the above checks contain adverse information, it may be grounds to deny opportunities working with Child, Youth and School Services programs.

Signature	Date Signed

SUPPLEMENTAL-A EMPLOYMENT APPLICATION FORM FOR CHILD-YOUTH SERVICES POSITIONS

For use of this form, see AR 215-3; the proponent agency is DCS, G1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Public Law 101-64.

PRINCIPAL PURPOSE: To determine your eligibility for service in a child care services position.

ROUTINE USES: We must have your social security number *(SSN)* to keep your records straight because other people may have the same name and birth date. The SSN has been used to keep records since 1943, when Executive Order 9397 asked agencies to do so. We may also use your SSN to make requests for information about you from employers, schools, banks, and other who know you, but only where allowed by law. The information we collect by using your SSN will be used for employment purposes, and also for studies and statistics that will not identify you. We may give information from your records to appropriated federal agencies such as the Department of Labor and the Equal Employment Opportunity Commission, to resolve and/or adjudicate matters falling within their jurisdiction. Records may also be disclosed to labor organizations in response to requests for names of employees and identifying information. Information we have about you may also be given to federal, state, and local agencies for checking on law violations or other lawful purposes.

DISCLOSURE: Your responses to the collection of this information are voluntary, but we cannot determine your eligibility, which is the first step toward getting the job, if you do not answer these questions.

1. NAME	2a. SSN	3. JOB ANNOUNCEMENT/TITLE
4. ADDRESS	2b. DOB *(YYYYMMDD)*	
	5. WORK PHONE	6. HOME PHONE
7. FAX TELEPHONE NUMBER	8. E-MAIL ADDRESS	

9. HAVE YOU EVER BEEN ARRESTED FOR OR CHARGED WITH A SEX CRIME, A CRIME INVOLVING A CHILD, A SUBSTANCE ABUSE FELONY OR A VIOLENT CRIME? HAVE YOU EVER BEEN ASKED TO RESIGN BECAUSE OF OR BEEN DECERTIFIED FOR A SEXUAL OFFENSE? If so, provide an description of the case disposition.

☐ YES ☐ NO

Note: A false statement rendered by an employee may result in adverse action up to and including removal. Under 18 U.S. Code 1001, the federal punishment for perjury is fine or imprisonment for up to 5 years, or both.

I declare under penalty of perjury that the information contained in this application form and any attachments ***or documents submitted in connection with my application for this position*** *are true and correct to the best of my knowledge, information, and belief.*

10. SIGNATURE	11. DATE *(YYYYMMDD)*