VOLUNTEER DRIVER REGISTRATION FORM
UNITED COMMUNITY ACTION PARTNERSHIP

Name _____ Birth date: _____

Address _____ City _____ Zip _____

Phone No. _____Cell Phone or On Star No._____ County _____

Check Driving Preference: ____ Local trips ____ Out-of-town (no metro) ____ Out-of-town (include metro)

List any special training, skills or previous volunteer experience.

_____

INSURANCE REGISTRATION INFORMATION (For Volunteer Drivers)

Driver's License Number _____
Any citations or accidents? _____ When? _____
Vehicles to be used:
Make _____ Year _____ (___ Two-door or ___ Four-door)
Make _____ Year _____ (___ Two-door or ___ Four-door)

Name of Auto Insurance Company _____
Name of Insurance Agent _____ Phone No. _____
Auto Insurance Policy No. _____

*****A copy of your proof of insurance card, drivers' license and current registration (which your current tabs came on) is required when registering.*****

I hereby state that I am carrying and will continue to carry automobile liability insurance that meets or exceeds Minnesota minimum financial responsibility requirements. I give United Community Action Partnership permission to confirm this with my insurance agent as long as I am registered and serving as a volunteer driver. I understand that my insurance is primary in case of an accident or passenger injury.

ENROLLMENT AGREEMENT: I, _____, volunteer my service through the Volunteer Transportation Program of United Community Action Partnership and understand that I am not an employee. I agree to provide or consent to the following: (1) A statement to be signed by a physician that no current medical conditions exist which interferes with my ability to safely drive an automobile. (A physical exam is NOT required.); (2) A signed release to verify my driving record, and a signed release for a criminal background check, as required by certain agencies; (3) A statement from a local mechanic that the vehicle used for volunteer driving is in safe operating condition; and (4) I will comply with the Code of Conduct.

I give permission to use my name and/or picture in news stories, news releases, etc. to help promote the program.
_____ Yes _____ No

_____ I would be willing to volunteer for other area transportation services.

_____ I would be interested in becoming an American Cancer Society volunteer. (STOP and make sure you have the Cancer Society registration forms in this packet).

_____ I would be interesting in signing up with ACE volunteer program.

_____ _____
Volunteer's Signature Date

_____ _____
Director's Signature Date

WELCOME

On behalf of United Community Action Partnership we would like to welcome you as a volunteer with our Transportation Program. With your assistance, we can provide a service that otherwise could not be provided. We thank you for dedicating your time and talents. We believe that you are unique because you have learned how to give of yourself to help others.

CODE OF CONDUCT FOR VOLUNTEERS

I will conduct myself with dignity, courtesy, and consideration. I will conduct myself in a professional manner and at the same time be friendly, understanding and courteous. (I will greet all passengers with a smile!!)

I realize, since I am a volunteer, I do not receive payment for my time. Furthermore, I will not insinuate or accept tips or request that my meals be paid by passengers.

Having been accepted as a volunteer, I will provide service according to the agency standards for paid staff and treat my volunteer work as seriously as if I were paid for it.

As a volunteer, I will not make derogatory or discriminatory remarks to or about passengers because of race, color, creed, religion, national origin, sex, disability, age, marital status, or status with regard to public assistance.

I will not impose my religious beliefs or lecture passengers.

I realize that sexual harassment or contact with passengers is inappropriate and not allowed.

I will not use alcoholic beverages or mood altering drugs while serving as a volunteer.

I will be punctual in the performance of my duties.

I understand I must respect the privacy rights of the passengers I serve. The Minnesota Government Data Privacy Act states that personal, medical, psychiatric and financial information is private, not public data. Information on these subjects may be shared with a dispatcher or other staff only if it is necessary in relation to the passenger's transportation needs.

I recognize that as a volunteer, I represent United Community Action Partnership. I have an obligation to uphold these codes of conduct.

_____

Signature

*** Volunteers violating codes of conduct may be dismissed at any time. ***

Informed Consent Form

Driver's License/Violation

Disclosure under the Fair Credit Reporting Act and Consent to Procurement of Consumer Report for Employment and/or Volunteer Purposes

I,_____, have made application with United Community Action Partnership (UCAP) public transportation services, and authorize UCAP or its insurance company, the Nonprofit Insurance Trust, or its assigned, to obtain copies of consumer reports, exclusively for a motor vehicle report and court record violation(s) pertaining to me for employment purposes, and for use in rating and/or underwriting insurance for which UCAP may apply, and any renewal thereof. I understand that in obtaining such reports, a consumer reporting agency may be used, and I do hereby authorize such use.

Additionally, I authorize the Minnesota Bureau of Criminal Apprehension to disclose criminal history information to United Community Action Partnership (administrative staff for the purpose of performing services for the Transportation Program.

Full Name of Driver Applicant (please print):

_____

Last First Middle (Maiden, Former, Alias)

Address: _____ **Phone:** _____

Street

_____

City, State, Zip Code

Date of Birth: _____

Month/Day/Year

Drivers' License Number: _____ **Issuing State:** _____

It is the policy of United Community Action Partnership (UCAP) that anyone will be prohibited from driving a vehicle for UCAP public transportation services unless he/she meets the following criteria for the length of time required by UCAP and its contractors:

a) has not had a driver's license canceled under Minnesota Statues, chapter 171 revoked under Minnesota Statutes, chapter 171, or suspended under Minnesota Statutes, chapter 171;

b) has a driving record clear of convictions for driving a motor vehicle without a valid current license for the class of vehicle driven;

c) for proceeding three years, has a driving and criminal record clear of convictions for driving under the influence of alcohol or a controlled substance under Minnesota Statutes, chapter 169, or an ordinance in conformity with that section, of alcohol-related driving by commercial vehicle drivers under Minnesota Statutes, chapter 169, and of driver's license revocations under Minnesota Statutes, chapter 169.

I willfully disclose this information to United Community Action Partnership. (The expiration of this authorization shall be for a period no longer than one year from the date of my signature:

_____ _____

Signature of Driver Applicant Date

_____ _____

Driving Record Reviewer's Signature Date

_____ _____

Reviewer's Signature of Driver's License Expiration Date

_____ _____

Reviewer's Signature of Medical Examiners Certificate Expiration Date

Revised 10/24/2016

Office use only

Background check coding: F Fund GL PP AG Loan R

___ _____ _____ _____ _____ _____ ___

UNITED COMMUNITY ACTION PARTNERSHIP

Volunteer Driver Transportation Program
Medical Statement

_____ has no known medical condition which would interfere with safe driving of a vehicle.
(Volunteer's name)

_____ I have reviewed the above listed individual's medications with him/her, and he/she **<u>may</u>** drive while taking these medications.

_____ I have reviewed the above listed individual's medications with him/her, and he/she **<u>may NOT</u>** drive while taking these medications.

*Please attach a current list of medications.

Additional Comments:

_____

_____

_____

_____ _____

Physician's Signature **Date**

_____

_____

Name and Address of Physician's Office

UNITED COMMUNITY ACTION PARTNERSHIP
Volunteer Driver Transportation program
Vehicle Inspection Statement

_____ _____
Volunteer Driver Name **Date**

Make of Vehicle	**Vehicle License Plate #**	**Color**	**2dr/4dr**
Make of Vehicle	**Vehicle License Plate #**	**Color**	**2dr/4dr**

ITEMS CHECKED SATISFACTORY

___Brakes	___Windshield Wipers	___Tires, Wheels, Rims	
___Steering	___Mirrors	___Oil and Fluids	
___Lights and Signals	___Exhaust	___Horn	___Other _____

Comments: _____

I certify this vehicle(s) is currently in a safe operating condition.

_____ _____
Signature of Mechanic **Date**

Name & Address of Auto Shop or Auto Dealer _____

_____

_____

_____
Phone # of Auto Shop

I understand vehicles should not be operated in such a condition liable to cause an accident or breakdown while serving as a Volunteer Driver for, United Community Action Partnership Inc.

_____
Signature - Volunteer Driver

Volunteer Driver Reference Check Form

Please provide an emergency contact and two (2) references who can attest to your safe driving ability. Your references MUST include: **a supervisor** from any other business or organization you have driven for in the last three (3) years **or a friend** who can attest to your driving ability, **AND a family member** other than your emergency contact.

EMERGENCY CONTACT

Name _____ Phone Number _____

Address _____

Relationship to you _____

REFERENCE #1

Name _____ Phone Number _____

Relationship to you _____ Best time to call _____

Name of business/organization _____

REFERENCE #2

Name _____ Phone Number _____

Relationship to you _____ Best time to call _____

Name of business/organization _____

The above reference information is provided accurately. I understand that reference checks will be performed periodically, at the discretion of United Community Action Partnership staff, and that alternate references may be requested as necessary.

Signature _____ Date _____

Privacy Notice

MINNESOTA DEPARTMENT OF HUMAN SERCIVES LICENSED FACILITIES EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES,

PROFESSIONAL SERVICES AGENCIES BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statutes, chapter 245C, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals providing direct contact services to people receiving services from facilities and agencies licensed by DHS. The background studies are to be completed according to the requirements in Minnesota Statues, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions of disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota States, chapter 245C, will be disqualified from positions allowing direct contact with persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified by an asterisk * is "optional" and may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact to persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney

Privacy Notice

MINNESOTA DEPARTMENT OF HUMAN SERCIVES LICENSED FACILITIES EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES,

General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards.

If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.

Volunteering for United Community Action Partnership's is contingent upon the timely receipt of the background study results establishing that prospective Volunteer has no disqualifying characteristics. United Community Action Partnership reserves the right to disallow any volunteering if the results of the DHS background study is not returned within ten (10) business days after the background study process is initiated, regardless of whether the results of the background study ultimately show you have a disqualifying characteristic or not.

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MINNESOTA DEPARTMENT OF HUMAN SERCIVES LICENSED FACILITIES EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES,

All information is required unless it does not apply to you, such as a prior address.
Please print legibly as errors could cause delays or ineligibility.

GENERAL INFORMATION

NAME: First: _____ **Middle:** _____ **Last:** _____

Date of Birth: _____ **(mm/dd/yyyy)** **Gender: Male**____ **Female**_____

Race: _____ **Eye Color:** _____ **Hair Color:** _____

Height: _____ **Weight:** _____ **U.S. Citizen: Yes**____ **No**_____

ID# :_____ **Expiration Date:** _____

ID Type (Driver's License, State ID, Visa, etc.): _____

Issuing State/Authority: _____

SSN: _____ **(9 numbers)** **Phone:** _____

Place of Birth (state if in the U.S., country if outside the U.S.): _____

Email: _____ **Today's Date:** _____

ADDRESS

Address: _____

State: Minnesota **City:** _____ **Zip code:** _____

MAILING ADDRESS (if different from above)

Address: _____

State: Minnesota **City:** _____ **Zip code:** _____

---Continued on next page---

Privacy Notice

MINNESOTA DEPARTMENT OF HUMAN SERCIVES LICENSED FACILITIES EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES,

PRIOR ADDRESS (if lived out of Minnesota in the last 5 years)

State: _____ **City:** _____ **Zip code:** _____

Years lived there: From _____ **To** _____

PRIOR NAMES/ALIASES

Other names by which subject has been known (i.e. maiden name).

1. _____
2. _____
3. _____
4. _____
5. _____

For Office Use Only: Date Submitted to DHS _____ HR _____