



# PROJECT IMPACT COUNSELOR APPLICATION

Project IMPACT is a week-long youth service camp during which campers from rising grades 6 through 9 will complete various service projects in and around Thomas County. Project IMPACT counselors will act as role models, service learning teachers, and team leaders for the summer camp. Counselors will be expected to be available for the week of June 11-15, 2018 from 8:00am-3:30pm and for one orientation day prior to that week. This is an unpaid volunteer position. Students may be eligible to earn service or work credit hours.

Counselors *must be at least 16 years* of age by the first day of camp. They should have past leadership experience and a desire to be a good role model for younger kids. All potential Project IMPACT counselors must *have at least 3 verifiable references* along with a completed application. Counselors may be subject to a basic background check.

## PERSONAL INFORMATION

Name \_\_\_\_\_ Gender: M F  
 Current Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Evening ( ) \_\_\_\_\_ Day ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_  
 How long have you lived at this address? \_\_\_\_\_  
 Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthday Month/Day/Year \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Drivers License # \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 Is your driver's license in good standing? YES NO  
 Have you ever been convicted of a crime? YES NO If yes, please attach an explanation

T-shirt Size \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## WORK/VOLUNTEER EXPERIENCE (a resume may be attached instead)

<u>DATES</u>	<u>ORGANIZATION</u>	<u>POSITION</u>	<u>PHONE</u>	<u>SUPERVISOR</u>
<u>DATES</u>	<u>ORGANIZATION</u>	<u>POSITION</u>	<u>PHONE</u>	<u>SUPERVISOR</u>
<u>DATES</u>	<u>ORGANIZATION</u>	<u>POSITION</u>	<u>PHONE</u>	<u>SUPERVISOR</u>

**REFERENCES**

*3 verifiable references are required*

<b><u>NAME</u></b>	<b><u>RELATIONSHIP</u></b>	<b><u>PHONE</u></b>	<b><u>E-MAIL</u></b>
<b><u>NAME</u></b>	<b><u>RELATIONSHIP</u></b>	<b><u>PHONE</u></b>	<b><u>E-MAIL</u></b>
<b><u>NAME</u></b>	<b><u>RELATIONSHIP</u></b>	<b><u>PHONE</u></b>	<b><u>E-MAIL</u></b>

-Do you have a history of drug or alcohol abuse? YES NO  
 -Have you or are you in any drug or alcohol treatment program? YES NO  
 -Have you ever been treated for psychiatric or mental disorders? YES NO  
 -Are you taking any medication or do you have any physical limitations which would hinder your abilities to safely perform any of the duties of an IMPACT counselor? YES NO  
 -Have you ever been convicted of, or are you presently under investigation for any matter related to child abuse, sexual misconduct, violence, and/or possession or use of illegal drugs or alcohol? YES NO

**If you have answered "yes" to any of these questions, please provide details on a separate sheet of paper and staple your response to this application.**

**\*\*\*PLEASE NOTE\*\*\***

I understand that making any false statement on this application will be sufficient for discharge. I hereby guarantee the correctness of the above statements. I hereby authorize you to contact my references and complete a background check. I understand that this is an application only and not a guarantee of a position.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are under 18, a parent must also sign this application and attached release

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE SUBMIT YOUR APPLICATION BY APRIL 15, 2017**

**By Mail: Hands On Thomas County  
Attn: Angela Kiminas  
P.O. Box 252, Thomasville, GA 31799**

**In Person: 120 E. Monroe St., Thomasville, GA 31792**

**E-mail: [info@handsonthomascounty.org](mailto:info@handsonthomascounty.org)**

## LIABILITY WAIVER

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Liability waiver: I acknowledge that my participation, and that of any minors that accompany me, is completely voluntary on my part and is being undertaken without promise or expectation of compensation. I, the above-signed, for myself, my heirs, and assigns hereby release and discharge Hands On Thomas County (HOTC), its affiliates, associates, and agents and any participating organizations, for any claims for damages or injury I may incur resulting from my participation in this voluntary community service event. I understand that my participation involves risk of injury and that illness may result directly or indirectly from my participation. I further state that I am in proper condition for participating in these events. I agree to abide by the rules established by HOTC and its partners relative to health and safety requirements. I agree not to accept any tasks that I /we am/are not physically able or comfortable doing. I accept responsibility for the possible loss or damage to personal property, physical & mental well-being, risk of injury, and behavior of myself, and any minors that accompany me. I also give my permission to HOTC to reproduce any photographs or video taken during this project.

I hereby release Hands On Thomas County of Thomasville, Georgia, its staff, Board and volunteers from responsibility and liability for any injury, damage or illness due to gross negligence that I may sustain just before, during and after Youth Service Camp. In the event of an emergency, I hereby authorize a leader of said activities, as agent for me, to consent to any X-ray examination; medical, dental, or surgical diagnosis, treatment, and/or hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) either at a doctor's office or in any hospital. I further authorize the staff, leaders or volunteers to administer any immediate first aid treatment that may be deemed necessary. In case of emergency, the person indicated below will be contacted as soon as possible. I hereby deem that this release is effective for Project IMPACT Youth Service Camp activities for the week of June 11-15, 2018.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature (if under 18) \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Phone Number(s) \_\_\_\_\_

### **Medical Information**

Allergies \_\_\_\_\_

Medications being taken \_\_\_\_\_

Physical handicaps or limitations \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Member's Name \_\_\_\_\_

*Please attach a copy of the front and back of your insurance card.*