Cleveland Clinic Lou Ruvo Center for Brain Health is an Equal Opportunity Employer, and as such prohibits discrimination due to race, religion, gender, age, national origin, and physical or mental handicaps. Completion does not guarantee placement. Decisions concerning assignments are contingent upon a successful interview, references and TB testing.

Student Application (16-18)

Name_____Date of Application_____

Mailing Address _____City/State/Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Email address_____Preferred Contact_____

Goals for your experience at Cleveland Clinic Lou Ruvo Center for Brain Health (CCLRCBH)_____

_____

Date available to begin_____ Total hours per week_____

Limitations

Are there any reasonable accommodations we should consider? Yes No

If yes, describe:_____

_____

Emergency Contact Information

Name_____Relationship_____

Address_____City/State/Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Education

School Name	City/State	Last grade completed	Graduate?	Degree/Diploma

Are you bilingual? Language_____Speak_____Read_____Write_____

Language_____Speak_____Read_____Write_____

If called upon would you be willing to assist staff as an interpreter if needed? Yes No

Please list any verified volunteer service you have done in the past

Organization	Organization
Address	Address
Dates: from to	Dates: from to
Assignment	Assignment
Supervisor	Supervisor
Phone	Phone

Person(s) employed with CCLRCBH with whom you are related:

Name_____Dept_____Relationship_____

(Students will not be assigned to same area as related employee.)

Applicant Statement

I certify that the information provided in this application is complete and accurate to the best of my knowledge. I understand that if I am accepted as a volunteer, statements discovered to be incorrect or misleading will be cause for my immediate termination. Cleveland Clinic Lou Ruvo Center for Brain Health has permission to contact directly references I have listed or any other sources concerning my prior volunteer history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Applicant Signature_____ Date_____

Parent/Guardian Name_____ Date_____
(Print)

Parent /Guardian Signature_____

Cleveland Clinic
Lou Ruvo Center for Brain Health

VOLUNTEER SERVICES REFERENCE FORM

Name of Reference_____

Address_____
Street City State Zip

Reference e-mail address_____ Phone_____

Applicant_____

The above applicant has applied for a volunteer position with Cleveland Clinic Lou Ruvo Center for Brain Health. We would appreciate your cooperation in checking the appropriate spaces below as they pertain to your knowledge of this applicant. Return this form at your earliest convenience, as the applicant's file is not complete without verified references. Thank you for your anticipated cooperation.

Dee King, Director of Volunteer Services
dking@keepmemoryalive.org
Fax: 702-260-9797

Number of years you have known applicant _____

Relationship to applicant: (friend, relative, employer, etc.) _____

Please indicate how you rate the applicant with regards to the following four character qualities:

	POOR	FAIR	AVERAGE	ABOVE AVERAGE	OUTSTANDING
Reliability					
Confidentiality					
Commitment					
Integrity					
Creativity					

Cleveland Clinic Lou Ruvo Center for Brain Health has my permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Student Signature _____ Date_____

Reference Signature_____ Date_____

Photograph, Film or Vocal Recording Release

Note: I authorize this release based on the following conditions:

- *These records become the property of Cleveland Clinic Foundation/Cleveland Clinic Health System or its representatives*
- *This release is given without promise of compensation*
- *This release is effective until terminated by a retraction in writing from the person granting this authorization*
- *The parent/legal guardian and the subject do release to Cleveland Clinic Foundation any right, title and/or interest of*

A. Release to photograph, film or record vocally

The Cleveland Clinic Foundation\Cleveland Clinic Health System ("CCF") is committed to educating the public and other healthcare providers.

I hereby grant to CCF the right and authority to photograph, film and/or record vocally:

_____

Please Print **Subject/Patient (or child's) name** **Age**

I hereby authorize the use and disclosure of my name, voice, image or likeness, including still photo, film and/or videotape and audiotape. I understand I have the right to request cessation of recording or filming at any time.

I understand this Authorization is in effect until it is revoked in writing. It may be revoked at any time to the extent that use or disclosure has not already occurred prior to my request for revocation. In order to revoke the authorization, I agree that I must notify ___Nicole Wolf_____ in writing at wolfn@ccf.org or by telephone at 702-263-9797. CCF shall through reasonable efforts attempt to cancel already published works incorporating my Released Information, however, CCF cannot guarantee the cancellation of such published works in part due to the fact that revocation may be impractical or impossible due to the nature of internet based news media and downstream access to additional sites

I agree the photos or images specified above become the property of CCF or its representatives and I waive the right to inspect or approve such work.

I agree this Authorization is given without promise of compensation. I further agree to release to CCF any right, title and/or interest of any kind they may have in the information or images produced and any direct/indirect remuneration to CCF. I agree to release and forever discharge CCF, its agents, officers and employees from any and all claims including arising out of or in connection with the use of said information, including but not limited to any claims for invasion of privacy, right to publicity or defamation.

By signing below, I authorize CCF to use or disclose any personal likeness information specified in this Authorization.

_____ _____

Signed (parent or legal guardian) **Date**

_____ _____

Print Name of student **Phone number**

Cleveland Clinic
Lou Ruvo Center for Brain Health

Keep Memory Alive

Youth Tuberculin Skin Test Consent Form

To be taken after orientation is completed

I hereby give my consent to Cleveland Clinic to provide the Tuberculin (TB) Skin Test to:

_____

(Print student's name)

a minor, my child, for the purpose of his/her participation at the Cleveland Clinic Lou Ruvo Center for Brain Health.

I fully understand that TB testing is Cleveland Clinic policy and a requirement. I am aware that my child will need to return to the facility where the TB test was administered within 48-72 hours for documentation of skin test results. I also understand that it is my child's responsibility to receive a copy of the results to bring to his/her assignment interview.

_____ _____

Parent/Guardian Signature Date

This form serves to introduce you as a volunteer at Keep Memory Alive of Behalf of the Cleveland Clinic Lou Ruvo Center for Brain Health.

Please collect a copy of the results and bring to your interview. Cleveland Clinic Lou Ruvo Brain Center volunteers receive an annual 1 (one) step TB test.

Test may be taken at the following locations, call for specific days the test. There is no fee.

Center for Occupational Health and Wellness
Contact: Nichole Stallworth (Office Manager)
801 S. Rancho Dr. Ste. F1
Las Vegas, NV 89106
Phone (702) 474-4454
Fax (702) 474-4424

OR

9005 S. Pecos Road Suite 2610
Henderson, NV 89074
Phone (702)-474-0472
Fax (702)-474-4012

Dee King, Director of Volunteer Services
Phone: 702-331-7046
Fax: 702-260-9797
dking@keepmemoryalive.org