

Date: _____



Creative Mentoring®

A Program of Creative Grandparenting,® Inc.

MENTOR APPLICATION FORM

The information provided in this application will help to match you with a student and will be kept confidential. PLEASE PRINT ALL INFORMATION.

First Name _____ MI _____ Last Name _____

Birth Date _____ Last 4 Digits of SS# _____

Street Address _____

Complex _____

City _____ County _____ State _____ Zip _____

Home Email _____

Home Phone () _____ Cell Phone () _____

Gender Female Male

Race African-American Asian Caucasian Hispanic Other _____

EMPLOYER INFORMATION

Company Name _____

Occupation/Title _____

Length of Current Employment _____ Year(s) _____ Month(s)

Street Address _____

Complex/Suite _____

City _____ County _____ State _____ Zip _____

Work Phone _____ Ext. _____ *May we call you at work?* Yes No

Fax # _____ Work Email _____

REFERRAL

How did you hear about the Creative Mentoring program? Church Friend Work

Magazine Newspaper Poster School Radio TV Other

Referral Name _____

Are you currently affiliated with any other mentoring program(s)? Yes No

If so, which program(s)? _____

REFERENCES

Please list the names and **DAYTIME TELEPHONE NUMBERS** of three (3) persons (non-family members) who have known you for at least three (3) years either personally or professionally. PLEASE PRINT.

Reference #1

Name _____ Phone _____ Alt Phone _____

Years Known _____ Relationship _____

Reference #2

Name _____ Phone _____ Alt Phone _____

Years Known _____ Relationship _____

Reference #3

Name _____ Phone _____ Alt Phone _____

Years Known _____ Relationship _____

SCHOOL INFORMATION

First School Choice _____

Second School Choice _____

When are you available to mentor? *(Check all that apply)*

Morning Monday Tuesday Wednesday Thursday Friday

Lunchtime Monday Tuesday Wednesday Thursday Friday

Afternoon Monday Tuesday Wednesday Thursday Friday

What grade level do you prefer? *(Check all that apply)* K - 2 3 - 5 6 - 8

ABOUT YOURSELF

Emergency Contact Name _____ Phone _____

Please tell us about yourself: Interests, Family, Volunteer Activities, etc.

Have you ever mentored or worked with children before? *(Please tell us about your experiences)*

Other Languages Spoken _____

Have you ever been arrested? Yes No

Had any involvement with the police or courts? Yes No

If you answered yes to either of the two questions above, please explain:

Please return completed application packet to:

Creative Mentoring
100 W. 10th Street, Suite 1115
Wilmington, DE 19801

Phone: 302-656-2122
Toll-free: 1-800-202-9050
Fax: 302-656-2123
www.creativementoring.org

**SCHOOL MENTOR PROGRAM
CRIMINAL HISTORY RECORD SCREENING AUTHORIZATION**

(Please print or type all information in black ink)

VOLUNTEER:

LAST NAME FIRST NAME MIDDLE SUFFIX

ALL OTHER FULL NAMES USED IN THE PAST:

1. _____
2. _____
3. _____

DATE OF BIRTH: _____ **RACE:** _____ **SEX:** _____
Month Day Year

SOCIAL SECURITY NUMBER (REQUIRED): _____

ADDRESS: _____
STREET

CITY STATE ZIP

TELEPHONE NUMBERS: () _____ () _____
HOME WORK

AUTHORIZATION TO RELEASE INFORMATION:

I authorize release of any and all information that you have concerning me, including CRIMINAL HISTORY RECORD INFORMATION and other information of a confidential or privilege nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information.

SIGNATURE DATE

SCHOOL PERSONNEL: It is recommended that each volunteer's driver's license be photocopied and kept on file with a copy of this form.

Forms should be mailed to: Creative Mentoring
100 West 10th Street
Suite 1115
Wilmington, DE 19801

For information or questions call:
Delaware State Police, Criminal History Section
1-800-464-4357 or 739-2528
(P.O. Box 430, Dover, DE 19903)

STATE BUREAU OF IDENTIFICATION USE ONLY:

SIGNATURE/DATE No Delaware Criminal History Record based on a name and date of birth check.

SIGNATURE/DATE The Delaware Criminal History Record is attached.

This Criminal History Record check is based on a name, date of birth and Social Security number only. No fingerprints were provided. Fingerprints provide the only "Positive" means of determining whether an individual has a Delaware Criminal History Record.



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Mentor Agreement

As a Creative Mentor, I _____ agree
(Print Name Here)

- To attend an *Elements of Effective Mentoring* or *Mentoring in the Middle* training session before beginning to mentor.
- To meet with my mentee for 30 minutes to one hour each week, for at least the remainder of the current school year. (I understand that continuing this relationship beyond this school year is encouraged.)
- To be on time for my scheduled mentoring sessions.
- To notify the school or school coordinator if I am unable to attend my weekly mentoring session.
- To engage in the mentoring relationship with an open mind.
- To ask for help and accept assistance from my mentee's teachers, support staff, and school coordinator when necessary.
- To keep discussions with my mentee confidential except where his/her safety and/or welfare may be in jeopardy.
- To notify Creative Mentoring and the school coordinator of any changes in my employment, address, and/or telephone numbers.
- To notify the school coordinator if I wish to change my assigned student or schedule.
- To complete and submit a Creative Mentoring end of year evaluation when due.
- To notify Creative Mentoring and the school coordinator if I no longer wish to mentor.
- To attend a Creative Mentoring training session once every two years to renew my mentor certification.
- **To meet with my mentee only in school or during school-sponsored activities as stated in his/her parents' permission form.**

Signature

Date

NAME: _____ DATE: _____



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HEALTH QUESTIONNAIRE FOR VOLUNTEERS

All school employees are required to have a tuberculosis (TB) skin test. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. In the same way, this questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further screening. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential matter.

Please consider the following questions:

1. Have you ever lived with or been in close contact with anyone who had TB disease?
2. Have you ever had a positive HIV test?
3. Have you ever used illegal intravenous drugs?
4. Have you ever been incarcerated?
5. Have you ever been homeless?
6. Do you currently have any of the following symptoms that are unexplained and that have lasted at least three weeks?
 - Cough
 - Fever
 - Night sweats
 - Weight loss
7. Consider the list of countries/continents below:
 - Africa
 - Asia, including China, Vietnam, Korea, Indonesia, Pakistan and Bangladesh
 - Eastern Europe, including Russia and the former Soviet Union, Armenia
 - Haiti
 - Latin America, including Mexico, Guatemala, and South America
 - Pacific Islands, including Philippines

Were you born in one of these countries?

Have you ever stayed/lived in one of these countries for one month or longer?

Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for one month or longer?

Can you answer "yes" to any of the above questions? () YES () NO

If you checked **yes**, you are **required** to have a Mantoux test before your assignment as a volunteer.

Have you ever had a positive skin test for tuberculosis? () YES () NO

If you checked **yes**, you are **required** to provide documentation related to current disease status before your assignment as a volunteer.

These requirements are for the safety of our school and for your personal health. Screening for tuberculosis is recommended by health professionals for any individual who is at risk. Routine screening, using a Mantoux tuberculin skin test, can detect if a person has been exposed to tuberculosis. Such early identification is of great benefit in reducing the effects of the disease.

If you have any questions about your risk of infection, please speak with your healthcare provider or plan to discuss it at your next examination. For additional information, you can contact the Delaware Division of Public Health TB Elimination Program at (302) 739-6620.

Approved by Division of Public Health, May 1999.

Creative Mentoring® Training Registration Form

Please mail or fax this completed application to Creative Mentoring®

Please Print.

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

First Name: _____

Last Name: _____

H Phone: _____

Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

W Phone: _____ Extension: _____

Fax: _____ Email: _____

<i>Mentor program affiliation (please check one):</i>		
<i>Please note that a program must be checked before we can process your registration.</i>		
<input type="checkbox"/> Creative Mentoring®	<input type="checkbox"/> Big Brothers Big Sisters	<input type="checkbox"/> VISTA
<input type="checkbox"/> Mentor DE/Indian River	<input type="checkbox"/> Other _____	

Class Choice

****Date:** _____ **Time:** _____ **Location:** _____

Class Type: (Please circle one) Elementary Middle 1 Middle2

I would like my confirmation sent via: Mail Email Fax

****You will receive a confirmation with directions to your class via email unless otherwise specified.**

If you do not receive your confirmation or if you are registering less than one week prior to the class, please contact Creative Mentoring® toll-free at 1-877-202-9050, Extension 15.

Mail: Creative Mentoring®
100 W. 10th Street, Suite 1115
Wilmington, DE 19801

Phone: (302) 656-2122
Fax: (302) 656-2123