

CAM- Community Action Ministries, Inc

819 Terrace Pl., Norman, OK 73069

***This will be valid for all activities during May 2010- May 2011.**

Adult Volunteer Personal Inventory

General Information

Name: _____ Date: _____ SS# _____

Address: _____ City/St./Zip: _____

Ph: Home _____ Mobile/Pager: _____ Work/Other: _____

E-mail: _____ DOB: _____ Age: _____

Do you give CAM permission to run a background check on you? _____

What is your relationship status?

Not seeing anyone Not dating exclusively Dating seriously Engaged Married

Spouse's name _____

Dependent's name(s) and age(s)

1. _____ 3. _____

2. _____ 4. _____

Education and Training Background:

Highest level of schooling completed: (e.g. High School Graduate, GED, Vo-tech, BS, PHD, and Masters)

Degree(s) in: _____

Employer: _____ Position: _____

Employment Status: Full Time Part time Temporary Seasonal On Call

Personal Information

1. Have you ever been convicted of a misdemeanor or felony? yes no If yes, when? _____

Explain: _____

2. Have you ever been convicted of child abuse or a crime involving actual or attempted sexual molestation?
 yes no If yes, when? _____

Explain: _____

4. Would you be willing to drive participants during a CAM event? ___yes ___no

If yes:

Do you have a current driver's license? ___yes ___no

Please list the type of license and the license number _____

Please attach a copy of your driver's license

Do you give CAM, Inc permission to obtain a MVR? ___yes ___no

5. What type of work would you like to volunteer for?

_____ A) Driving a van during activities (must be over 25 to drive a 15 passenger)

_____ B) Supervise over a group of young people during volunteer work

_____ C) Pick up/make meals during summer camps

_____ D) Making participants feel welcomed (send cards)

_____ E) Games & Entertainment, team building activities

_____ F) Help with volunteer projects

_____ G) Help with website design and development

_____ H) Help with media (news letter, advertising, and promotions)

_____ I) Fund Raising

_____ J) Provide Childcare for volunteers

_____ K) Other: _____

Please Read Carefully

I, _____(name), wish to volunteer my time and participate in activities sponsored by Community Action Ministries, I understand that some of the activities could involve a degree of risk and participation in the activities may result in the need for medical or dental care and treatment. In view of the fact that Community Action Ministries is an organization in which membership and participation is voluntary, and having full confidence that precautions will be taken to ensure the safety and well-being of participants, I consent to participate in the activities sponsored by Community Action Ministries, Inc during the period from May 15, 2010 to May 14, 2011.

Do you have any disabilities, handicaps, present injuries or limitations, allergies, hemophilia, heart condition, history of respiratory illness or any other significant medical condition? (Please include any prescription medication(s) and dosage.) ___Yes ___No If Yes, please state issues:

(Use another sheet of paper if necessary)

Emergency Contact: _____
Name Relationship Phone Number

If you wish your family doctor contacted in case of an emergency (conditions and situation allowing):

Doctor's name _____ Phone number: _____

Do you currently have valid health insurance? Yes _____ No _____

I certify that I have personal health insurance with:

Company	Policy #	Exp. Date
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By signing below I hereby acknowledge and agree that my health insurance will be the coverage provider for any illness or injury I receive or suffer during the duration of any of the events I participate in with Community Action Ministries. I also acknowledge and agree that Community Action Ministries does not provide health insurance to cover me in the event of an injury or illness.

I further acknowledge and agree that I shall be liable for all costs and expenses incurred in connection with any medical and dental services rendered to me pursuant to this authorization. Should it be necessary for the undersigned to return home, due to medical reasons, or otherwise, I agree to assume all transportation costs incurred.

Waiver of Liability and Disclaimer

I acknowledge that generally the individuals who administer the programs of CAM, volunteer their time and are not paid professionals. In consideration for allowing me to participate in its programs, I hereby agree to indemnify, release, discharge and hold harmless, Community Action Ministries, Inc., its employees, volunteers, Board of Directors, and other representatives from any and all claims and losses arising out of or relating to any physical injury, including death, as well as all property damage or loss that may result to myself while participating in any CAM, Inc.

Statement of Truthfulness

I further state and aver that the information I have given in this personal inventory is correct and complete to the best of my knowledge. I understand and agree that false information or significant omission of material information may disqualify me from further consideration for service and may be considered justification for dismissal if discovered at a later date.

Applicant's Signature _____ Date _____

To participants regarding insurance:

Community Action Ministries assumes no financial responsibility for medical cost of an accident occurring to a participant while participating in any CAM event. An accident insurance program is offered for your convenience. Neither CAM, Inc nor any agent of CAM, Inc is compensated by the Insurance Company.

Please see attached form (page 7-10) for more details concerning the purchase of this accident insurance. **For assistance in purchasing insurance, please contact Adams & Associates International at 1-800-922-8438 and ask for the volunteer department.** If you chose to purchase this insurance, you will need to send your information by mail no later than 12 days before the event, or if you go on line, you can purchase it 2 days before the events.

This form is to acknowledge that I have received information regarding policy pertaining to accident injury insurance, and wish to take out a policy while participating in a CAM event.

Name (print)

Participant's Signature

Date

Effective date of insurance



We have adequate Insurance and do not wish to participate.

Name (print)

Participant's Signature

Date

COMMUNITY ACTION MINISTRIES
VOLUNTEER BEHAVIOR AGREEMENT

By his or her signature following, the undersigned Volunteer covenants and agrees with Community Action Ministries, Inc, (“CAM”), as follows:

1. I shall make all efforts to prevent emotional, physical, or sexual abuse of CAM’s youth participants.
2. As a volunteer participant with CAM, I understand and agree that I shall not engage in any practice that would intentionally harm a youth emotionally or physically.
3. As a volunteer participant, I also agree not to engage in any sexual behavior of any kind with any youth. That includes inappropriate touching, intimate sexual contact, sexual gestures, sexual jokes and statements, exhibitionism, actions or speech designed to arouse sexually, and actions or speech designed to encourage sexual experimentation.
4. I agree not to discuss sexual issues or sexuality with any youth participating in CAM activities, without written permission from the youths’ parent or legal guardian.
5. I understand that sexual abuse of a minor is a crime. I understand that the leadership of CAM will cooperate fully with any and all law enforcement agencies when abuse or allegations of abuse occur.
6. I will take every reasonable precaution not to be alone or out of sight of the group with any youth. If I feel an individual needs private counseling, I will ask another adult to join me. If no one is available at that time, I will set up a time when another adult will be available.
- 7. I agree to abide by the provisions of this Volunteer Behavior Agreement and to refrain from activities that are illegal or unethical while I am working in any capacity within CAM.**

Agreement to Abide by Volunteer Behavior Agreement

As an integral part of my participation, I further agree to adhere to and comply with all of the provisions of the Volunteer Behavior Agreement and any other reasonable and appropriate requests of Community Action Ministries, Inc.

Signature: _____ Date: _____

Request for Criminal Records Check and Authorization

I hereby request the Oklahoma State Bureau of Investigation (OSBI) to release any information, which pertains to any record of convictions contained in its file maintained on me whether local, state, or national. I hereby release Community Action Missions (CAM), a ministry of Great Life Church from any and all liability resulting from such disclosure.

Signature

Print First, Middle, and Last Name

Print maiden name if applicant

Print all aliases, including all married names

Date of Birth

Place of Birth

Social Security Number

Today's Date

Background check completed: Date: ___/___/___ clear record ___ yes ___ no

For more information, please contact:

Donna Hooper, Director
Home: (405)329-8041 Cell: (405)887-1787
donna@communityactionmissions.com

Mail form to:

CAM
PO Box 1674, Norman OK 73070

Travel Accident Insurance Benefits Volunteers on Mission in the USA and Canada

*Travel Accident Insurance for Southern Baptist Groups Performing Mission Activities within
the USA and Canada.*

Coverages

Basic Travel Insurance at a competitive cost for the following Volunteers Ages 10 and Over:

1. Short Term (serving 30 days or less)
2. Long Term (serving 30 days or more)

Those Under Age 10 are eligible for Plan B" Only

Insurance becomes effective for each eligible person on the date a completed enrollment form is received by the company and is provided for covered activities only. Coverage terminates on the earlier of the termination date of the Policy or the date the person ceases to be eligible.

Accidental Death and Dismemberment Benefit and Paralysis Benefit

If Injury to the Insured Person shall result in one of the following losses within 365 days from the date of covered accident, the Company will pay the percentage of the Principal Sum specified below:

Loss of:	Percent of Principal Sum	Plan "A"	PLAN "B"
Life.....		100%	100%
Two Hands, Two Feet or the Sight of Both Eyes.....		100%	100%
One Hand and One Foot.....		100%	100%
One Hand and the Sight of One Eye.....		100%	100%
One Foot and the Sight of One Eye.....		100%	100%
One Hand, One Foot or the Sight of One Eye.....		50%	50%
Thumb and Index Finger.....		25%	25%
Quadriplegia.....		300%	100%
Paraplegia.....		200%	75%
Hemiplegia.....		100%	50%

"Loss" shall mean, with reference to hand or foot, complete severance through or above the wrist or ankle joint; with reference to sight of any eye, the entire and irrecoverable loss of sight thereof; with reference to thumb or index finger, severance through or above the metacarpophalangeal joint; with reference to quadriplegia, the complete and irreversible paralysis of both upper and lower limbs; with regard to paraplegia, the complete and irreversible paralysis of both lower limbs; and with regard to hemiplegia, the complete and irreversible paralysis of upper and lower limbs on one side of the body. If more than one of such specified losses shall result from the same accident, only one amount, largest, shall be paid.

Permanent Total Disability Benefit

When as the result of Injury an commencing within 90 days of the date of accident and Insured Person in totally and permanently disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which he is reasonably qualified by reason of his education, training or experience, the Company will pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the end of this period, the Principle Sum less any amount paid under the Accidental Dismemberment Indemnity coverage as a result of the same accident, at a rate of one percent per month for 100 months.

Accidental Medical Expense Benefit

If Injury to the Insured Person shall required treatment by a physician, the Company will pay the Usual and Reasonable covered expenses actually incurred after the satisfaction of the deductible for such services, treatment or supplies up to the maximum amount, provided the first expense is incurred within 30 days of the accident causing Injury. The expenses must be incurred within 52 consecutive weeks after the date of accident. **Benefits are payable only in excess of any expenses payable by other valid and collectible group insurance.**

Services must be approved by the attending physician and include but are not limited to the following: charges for semi-private hospital room and board, use of the operating room, emergency room, and Ambulatory Medical Center; fees of Physicians; Medical Expenses, in or out of the Hospital, including lab tests, prescription medicines, anesthetics, artificial limbs or eyes, ambulance service, therapeutics, transfusions, x-rays, and prosthetic appliances; and charges for registered nurse.

Please See Next Page For More Information

The Aggregate Limit of Indemnity of \$1,000,000 shall be the total limit of the Company's liability for all indemnities payable with respect to all Insured Persons arising out of Injury sustained by two or more Insured Persons as the result of any one accident.

Plan Design and Rates:	Plan A	Plan B
Principal Sum:		
Accidental Death and Dismemberment.....	\$100,000	\$100,000
Accidental Medical Expense		
Maximum Amount.....	\$10,000	\$10,000
Sickness Medical Expense		
Maximum Amount.....	\$2,500	n/a
Deductible per occurrence (both Accident or Sickness).....	\$50	\$50
Emergency Transportation Expense Reimbursement	\$25,000	n/a
Cost per day of Service.....	\$0.88	\$0.51

Exclusions

Policy does not cover any loss, fatal or non-fatal, incurred for or resulting from the following: Suicide or any attempt thereof while sane or self destruction or any attempt while insane; Infections except pyrogenic infections caused wholly by a covered Injury; War or any act of war, or accident occurring while in the military, naval or air service of any country; Accident occurring while the Insured Person is operating, or learning to operate, or performing the duties as a member of the crew of any aircraft; Dental treatment except as a result of Injury to sound natural teeth; Replacement of eyeglasses or eye examinations for the correction of vision or fitting of glasses unless Injury has caused impairment of sight; Injury for which the Insured Person is entitled to benefits under any Workers' Compensation Act or Law or any similar legislation; Hernia of any kind; Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Definitions

"Injury" shall mean bodily Injury caused by an accident and occurring while the Policy is in force as to the person whose Injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the Policy

This is a summary of coverage only. For exact details, please refer to policy SRG 8046454 on file with the policyholder. Coverages are underwritten by AIG Life Insurance Company and are not available in all states. If there is any conflict between the provisions of this summary and those of the master policy, the provisions of the master policy will govern at all times.

Enrollment Procedure

The enrollment form should be completed fully by the group leader, travel agent or individual and the original copy returned with your premium to Adams & Associates International. We suggest that this enrollment be completed well in advance of your term of service.

Claims

Claim forms are enclosed in this brochure. Claims instructions are below. Each group leader should be furnished with a copy of these instructions and several of the claim forms. You may make copies of claim forms if additional copies are needed.

Please complete Accident Claim Report and attach bills or other information. Sign the form and have the physician's statement completed. On any accident medical expense claims indicate your policy number, employer's name, and insurance carrier's name, claims office address and phone number. Remember that the accident medical expense coverage is excess of other insurance you may have.

When writing or calling us about a claim, please identify yourself as a Southern Baptist Volunteer and identify the city and state of both your home and mission, sponsoring group, and dates of your particular mission so that we may promptly identify you and confirm your coverage.

All claims should be reported promptly to:



PO Box 5845
 Columbia, SC 29250-5845
 Tel: (803) 758-1400 Fax: (803) 252-1988
 E-Mail: aai@aaintl.com Internet: www.aaintl.com

Travel Accident Insurance Benefits Volunteers on Mission in the USA and Canada

USA Enrollment

**Please make photo copies of this form for use on future mission trips.
Enrollments can be done via the WEB: www.aaintl.com
Call for a **USER ID & Password****

Please Print

Name:		Date of Birth:	
Address:			
City:	State	Zip:	
Phone:	Fax:	E-Mail:	
Location of Project:	Nature of Project:	Sponsoring Church:	
Expected Date of Departure from Home:			
Expected Date of Arrival Back Home:			

Please note, this is not a major medical policy. Major Medical Coverage is available for individuals and groups on short-term and long-term volunteer missionary assignments. If this is a need specific to your group, please contact us for details.

Premium Computation Calculate Premium

Number of Persons	X	Number of Days	=	Number of Person Days
_____		_____		_____

Select Plan and

	Number of Person Days		Plan		Premium
Plan A	_____	X	.88	=	_____
or Plan B	_____	X	.51	=	_____

List of Persons or Attach List

	Name Beneficiary	Date of Birth	
1.			
2.			
3.			
4.			
5.			

If several persons are participating in a single project, but for different dates of service, please list these persons showing their dates separately, married couples traveling together should list both husband and wife. Travel agents or Group Leaders may attach roster in lieu of completing this list.

Make checks payable to Adams & Associates International and submit with the above information. Regardless of how you enroll for coverage, an e-mail confirmation of coverage will be sent. This will be your receipt. Mail conformations will be sent upon request.

Please advise Adams & Associates International of any changes in travel plans. Also, in the event of a claim, notify Adams & Associates International immediately per the claim instructions.

E-Mail, Mail or Fax to:



PO Box 5845
Columbia, SC 29250-5845
Tel: (803) 758-1400 / 800-922-8438 Fax: (803) 252-1988
E-Mail: aai@aaintl.com Internet: www.aaintl.com