THE ROMANIAN ORTHODOX EPISCOPATE OF AMERICA

CAMP VATRA FOR SENIORS

2009 STAFF Application

CAMP DATES

Sunday, July 12 – Saturday, July 18, 2009 (One Week)

Name:_____
Last First Middle

Address:_____
Street City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Birthdate: ____/___/_____ Age: _____ Social Security # : _____ -- _____-- _____
month / day / year

Driver's License Number: _____
Number State Exp. Date

Sex: M F Marital Status: single / married / divorced / widowed

Name of Parish You Attend: _____

City:_____State:_____

How often do you attend church services? RARELY MONTHLY WEEKLY
How often do you participate in Confession and Communion? NEVER YEARLY OCCASIONALLY REGULARLY
Have you worked at Camp Vatra before? Yes No Year(s): _____

EMERGENCY CONTACT
Who should we contact in case of emergency?

Name: _____ Relation:_____

Phone number(s): _____

EMPLOYMENT
Present Employer and Occupation: _____

PAST EMPLOYMENT. Please provide a record of employment.

Dates	Employer	Nature of Work	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For which position are you applying?

____ Cook/Kitchen ____ Grounds crew ____ General Staff

Please indicate in which of the following areas you have training or experience:

____First Aid/CPR ____ Certified water life safety

____Other (please specify)_____

Have you ever been convicted of any crime (other than a minor traffic violation)? Yes No If yes, please explain:

PASTORAL ENDORSEMENT: I verify that the person whose name appears on this application is a member of my parish:

PRIEST'S SIGNATURE: _____

PARISH: Name: _____City:_____

REFERENCES. Please attach two (2) letters of recommendation from people, not related to you, who have known you for at least three (3) years, and who have knowledge of your character, experience, and ability. Please provide here their names, addresses and phone numbers:

Name Address Phone

I verify that the above information is true and I understand that I must also fill out a **Authorization for Background Check and Voluntary Disclosure Form** and **Health History Form** and have a current *Tuberculosis Test.*

Signature: _____ Date: _____

Please mail all forms to:

Attn: Richard Grabowski
Camp Vatra for Seniors STAFF
P.O. Box 309
Grass Lake, MI 49240-0309

REQUEST, AUTHORIZATION, CONSENT AND RELEASE
FOR BACKGROUND INFORMATION
PLEASE TYPE OR PRINT

I, _____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME
(PLEASE INCLUDE Jr., Sr., II, III Etc.)

understand that in conjunction with my application for staff position (e.g. director, instructor, counselor, staff, nurse, etc.) with Vatra Seniors' Camp or Vatra Juniors' Camp, the Romanian Orthodox Episcopate of America (R.O.E.A.) may use the services of an outside agency to research and verify the information I have provided on my application for employment including my personal background, character, professional standing, work history and qualifications.

This agency may utilize various sources of information it deems appropriate including but not limited to: criminal conviction records, credit reporting agencies, workers Compensation records including any and all injuries in compliance with the Federal ADA Act, Department of Motor Vehicle records, current and former employers, military records, education records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information including but not limited to the above to the R.O.E.A. and any employed reporting agency.

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES, FOR POSITIVE IDENTIFICATION PURPOSES, REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. I HEREBY RELEASE THE R.O.E.A. AND ITS AGENTS, AND ALL PERSONS, AGENCIES, AND ENTITIES PROVIDING INFORMATION OR REPORTS ABOUT ME FROM ANY AND ALL LIABILITY ARISING OUT OF THE REQUEST FOR OR RELEASE OF ANY OF THE ABOVE-MENTIONED INFORMATION OR REPORTS.

_____ _____
Signed **Today's Date**

_____ _____
Printed Name **Position Applied For**

_____-_____-_____ ____/_____/____ _____ _____
Social Security Number **Date of Birth** **Driver's License #** **State**

Other names you have used or are also known as: _____

Current Address:_____

FormerAddress:_____

Former Address:_____

HEALTH HISTORY RECORD
As Required by the Michigan Department of Social Services

Name:_____
Last First Middle
Address:_____
Street City State Zip
Home Phone: ( ) _____ Work Phone: ( ) _____

Birthdate: ____/___/_____ Age: _____ Social Security # : _____ -- _____-- _____
month / day / year

Do you have any of the following conditions? (Check all that apply.)

____ Hay fever, asthma, wheezing **____Diabetes** **____ Speech impairments**

____ Exzema or skin rashes **____ Frequent colds, sore throats** **____ Heart problems**

____ Convulsions/seizures **____ Shortness of breath** **____ Other**

Please explain:

Operations or injuries:
Allergic reactions (food, penicillin, other drugs)
Any other special condition the nurse should be aware of:

MEDICATIONS NEEDED OR USED (include Psychiatric):

Kind	**Frequency**	**Dosage**	**Currently given? (Yes or No)**

IMMUNIZATION:

	Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping cough)	Measles	Rubella	Other
Date of Initial Immunization								
Date of most recent booster								

I VERIFY THAT I DO NOT HAVE A COMMUNICABLE DISEASE AND THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature:_____Date:_____