



# Connecting Generations

## Creative Mentoring Program

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 \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Previous States in Which You've Lived \_\_\_\_\_

Home Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Gender  Male  Female

Race  African-American  Asian  Caucasian  Hispanic  
 Indian  Native American  Other \_\_\_\_\_

### **References**

Please list the names and **DAYTIME** phone numbers of three people (**NON-FAMILY** members) who have known you for at least **THREE** years, either personally or professionally.

#### **Reference # 1**

Name \_\_\_\_\_ Years Known \_\_\_\_\_

DAYTIME Phone # \_\_\_\_\_ Relationship (NON-FAMILY) \_\_\_\_\_

#### **Reference # 2**

Name \_\_\_\_\_ Years Known \_\_\_\_\_

DAYTIME Phone # \_\_\_\_\_ Relationship (NON-FAMILY) \_\_\_\_\_

#### **Reference # 3**

Name \_\_\_\_\_ Years Known \_\_\_\_\_

DAYTIME Phone # \_\_\_\_\_ Relationship (NON-FAMILY) \_\_\_\_\_

**School Choice Information** (For a complete listing, please visit our website [www.connecting-generations.org](http://www.connecting-generations.org))

First School Choice \_\_\_\_\_ Second School Choice \_\_\_\_\_

What grade level do you prefer?  K-2  3-5  6-8  9-12

## **Employer Information**

Company Name \_\_\_\_\_

Occupation \_\_\_\_\_ Start Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone \_\_\_\_\_ May we call you at work?  Yes  No

## **Referral**

How did you hear about Connecting Generations? \_\_\_\_\_

## **About Yourself**

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Other Languages Spoken \_\_\_\_\_

Have you ever been refused participation in any other youth programs?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever been arrested?  Yes  No

Have you had any involvement with the police or courts?  Yes  No

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

\_\_\_\_\_

**As a condition of volunteering**, I give permission to conduct a background check on me, which may include a review of sex offender registries, child abuse and criminal history records or other records where required by local, state or federal law for volunteers working with youth.

The references listed will be contacted by phone.

Connecting Generations' records are not available for review by volunteers, children or parents/guardians. All personal information shall be treated in a confidential manner.

*Completion of this application does not guarantee acceptance into this program.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please return completed application packet to:

Connecting Generations  
100 W. 10<sup>th</sup> Street, Suite 1115  
Wilmington, DE 19801

Phone: 302.656.2122  
Fax: 302.656.2123  
www.connecting-generations.org



# Connecting Generations

## Creative Mentoring Agreement

As a mentor, I \_\_\_\_\_ agree  
(Print Name Here)

- To attend a Making the Connection training session before beginning to mentor.
- To meet with my mentee for 30 – 60 minutes 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 Connecting Generations and the school coordinator of any changes in my employment, address, email 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 Connecting Generations survey when requested.
- To notify Connecting Generations and the school coordinator if I no longer wish to mentor.
- To update my background check form and DE Child Protection Registry form every two years.
- **To meet with my mentee only in school or during school-sponsored activities as stated in his/her parents' permission form.**
- **To acknowledge that all social media contact information is prohibited. We do not have parent permission for mentors and mentees to have contact on social media websites, cell phones, or via email.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**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:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_  
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 W. 10<sup>th</sup> 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)

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**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.



# DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Fax or Mail Request to: OCCL, Criminal History Unit  
 Concord Plaza, Hagley Building  
 3411 Silverside Road  
 Wilmington, DE 19810  
 Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed**
- **Do not use a cover sheet**
- **Do not send duplicate requests**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed**

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## PART I. APPLICANT INFORMATION (*PLEASE PRINT CLEARLY*)

Name: \_\_\_\_\_  
Last First Middle

Other Name(s) used: \_\_\_\_\_ DE Driver's License # \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_  
mm-dd-yyyy

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Are you on the Delaware child protection registry for any substantiated cases of child abuse/neglect? [ ] Yes [ ] No

If yes, explain: \_\_\_\_\_

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Delaware child protection registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature (If applicant is under the age of 18) \_\_\_\_\_

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## PART II. AGENCY INFORMATION - (*MUST BE COMPLETED IN ORDER TO PROCESS*)

Agency Identification Number (if applicable): 1300

Contact ID: 1831

Requesting Agency Name: Connecting Generations

Address: 100 West 10<sup>th</sup> Street #1115, Wilmington, DE 19801

Phone: (302)656-2122 Ext. 10 Fax: (302)656-2123 Contact Person: Jennifer Marek

Contact Email: jmarek@connecting-generations.org

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### DSCYF USE ONLY:

The individual listed above (    is listed ) (    is NOT listed ) on the Delaware Child Protection Registry.

Date: \_\_\_\_\_ DSCYF Criminal History Unit \_\_\_\_\_

Volunteer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Volunteer Signature: \_\_\_\_\_

**DELAWARE DEPARTMENT OF EDUCATION<sup>1</sup>  
CONFIDENTIAL TUBERCULOSIS (TB) HEALTH QUESTIONNAIRE  
FOR VOLUNTEERS IN PUBLIC SCHOOLS**

*All school students, employees, and volunteers are required to be screening for Tuberculosis (TB)<sup>2</sup>. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. This questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further testing. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential manner. The questionnaire must be completed every five years. The volunteer may prefer to provide evidence of TB testing in lieu of completing the questionnaire.*

**Please consider the following questions and circle only ONE response in the box below<sup>3</sup>:**

<b>Can you answer "yes" to any of the questions below?</b>	
<p>1. In the past five years, have you lived or been in close<sup>4</sup>contact with anyone who had active, infectious TB disease?</p> <p>2. Do you currently have any of the following symptoms which are unexplained and which have lasted at least three weeks? Cough                              Fever Night sweats                      Weight loss</p> <p>3. Have you ever had a positive HIV test?</p> <p>4. In the past five years, have you ever used illegal intravenous drugs?</p> <p>5. In the past five years, have you been incarcerated?</p> <p>6. In the past five years, have you been homeless which resulted in living in a shelter or with others outside of your family, who were homeless?</p> <p>7. For the next two questions, refer to the TB-Endemic Countries list provided by the Delaware Division of Public Health.</p> <ul style="list-style-type: none"><li>• In the past five years, have you stayed/lived in one of these countries for 1 month or longer?</li><li>• In the past five years, have you lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?</li></ul>	<p><b>YES</b> <input type="checkbox"/>    <b>NO</b> <input type="checkbox"/></p>

If you checked YES, you are required (within 2 weeks) to provide verification from a licensed health care provider or the Division of Public Health that there is no communicable threat.

Have you ever had a positive skin test for tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If you checked <u>yes</u>, you are <u>required</u> to provide documentation related to current disease status prior to your assignment or continued assignment as a volunteer. If you have provided documentation of completing treatment for active or latent infection, no further documentation is required.</b>	

**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 or a TB blood test, such as the Quantiferon Gold TB Test, can detect if a person has been exposed to tuberculosis. Early identification of infection and completion of a course of antibiotic treatment significantly reduces the chance of developing active TB disease over the lifetime of infected individuals.

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 302-744-1050.

<sup>1</sup>Developed and revised in collaboration with the Delaware Division of Public Health: 2/2005, 7/2010, 7/2013, 5/2015.

<sup>2</sup>Regulation 805 can be accessed at <http://www.state.de.us/research/AdminCode/title14/800>.

<sup>3</sup>To maintain confidentiality of medical information, the employee should not provide an individual answer to each question. The employee's response of "yes" indicates that at least *one* of the seven questions is correct, which means a possible exposure. The employee should not indicate which one. The employee may prefer to provide evidence of TB testing in lieu of completing the questionnaire.

<sup>4</sup>CDC describes "close contact" as prolonged, frequent, or intense contact with a person with TB, while he/she was in infectious.



## Creative Mentoring® Training Registration Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Best time to Call: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email address: \_\_\_\_\_

*Mentor program affiliation (please check one):*

**Please note that a program must be checked before we can process your registration.**

Creative Mentoring®  Boys & Girls Club  Other \_\_\_\_\_

### **Please select a class from the current Training Schedule**

Available at [www.connecting-generations.org/creative-mentoring/training/](http://www.connecting-generations.org/creative-mentoring/training/)

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

I would like my confirmation sent via:  Mail  Email

You will receive a confirmation 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 Connecting Generations at 302-656-2122 ext 0018.**

Mail: Connecting Generations  
100 West 10<sup>th</sup> Street, Suite 1115  
Wilmington, DE 19801

Phone: 302.656.2122  
Fax: 302.656.2123

\*In case of inclement weather please check our website for any training changes or cancellations.