

VOLUNTEER APPLICATION AND SERVICE AGREEMENT COVER SHEET

Incomplete applications, including failure to disclose accurate information regarding any/all criminal convictions, will be **automatic grounds for denial** of your application. If you have any questions or need assistance with this application packet, please contact the Community Resources Manager prior to submission.

Please provide all information requested below

☒ New Volunteer ☐ Renewal ☐ Gate Clearance ☐ Brown Card

Volunteer Applicant: Jane Doe Student

Institution: California Rehabilitation Center

Service Group Name(s): The Claremont Colleges- Inside-Out Program

For Renewals, include length of continuous volunteer service (example, 1 yr. 5 yr. etc.) 1 year

☐ **Attachment A:** CDCR 966 (Rev. 01/21) Volunteer Application and Service Agreement

Shall include the following attachments: Resumes, Employment History, Academic Enrollments, Community Participation Certifications, Licenses, Ordination Documents, or Reference Letters to Wardens.

- ☐ **Attachment B:** CDCR 181 (Rev. 10/14) Primary Laws, Rules, and Regulations Regarding Conduct and Association with State Prison Inmates.
- ☐ **Attachment C:** CDCR 894 (09/19) Emergency Notification Information
- ☐ **Attachment D:** CDCR 7336 (Rev. 03/20) Employee Tuberculin Skin Test (TST) and Evaluation
- ☐ **Attachment E:** CDCR 7354 (Rev. 07/15) TB Infectious Free Staff Certification
- ☐ **Attachment F:** CDCR 1049 (08/08) Certification of Volunteer Participation
- ☐ **Attachment G:** CDCR 8019 (06/20) Nepotism and Fraternization Policy Acknowledgment
- ☐ **Attachment H:** CDCR 2301 (Rev. 05/20) PREA Policy Information for Volunteers and Contractors Part A
- ☐ **Attachment I:** STD 910 (Rev. 10/2019) Essential Functions Health Questionnaire
- ☐ **Attachment J:** CDCR 1887 (Rev. 08/08) Parent Consent for Participation (if applicable)

All of the above forms must be submitted with this packet.

Volunteer Signature: _____

Jane Student

Date: Today's Date

****Please note specific additional information/forms may be required at various Institutions****

Volunteer Applicant: JANE STUDENT
Institution: California Rehabilitation Center

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐ RENEWAL

VOLUNTEER APPLICATION AND SERVICE AGREEMENT

SECTION I: To be Completed by Applicant (PRINT CLEARLY)

Name JANE DOE STUDENT Date of Birth: 02/01/2004
First MI Last (MM/DD/YYYY)

Address: 1234 SESAME STREET #143 CLAREMONT, CA 91711
Number and Street Apt. # City State Zip

Email (optional): jane.doe@student.pitzer.edu

SSN# (optional): _____ State Driver's License or Identification # (required): CALIFORNIA
B7060525 Exp.: 08/2024 OR

Passport# COUNTRY-PASSPORT NUMBER (If applicable) Exp. Date: 08/2025

Phone # (required): (800) 241-2211 Cell #: () _____ Fax # (optional): () _____

Gender: ☐ Male ☒ Female Height: 5'10 Weight: 150 Eye Color: BROWN Hair Color: BLACK

Occupation: STUDENT

Special Skills/Certificates: N/A

Name and address of company/church/organization you will represent as a volunteer (If applicable): THE CLAREMONT COLLEGES
1050 N. MILLS AVE. CLAREMONT, CA 91711

1. Have you submitted Live Scan fingerprints to CDCR in the past? ☒ No ☐ Yes (If yes, provide date and location/institution.)
2. Do you provide volunteer service at any other CDCR institution? ☒ No ☐ Yes (If yes, provide date and location/institution.)
3. Do you visit and/or correspond with any inmates at any other CDCR institution? ☒ No ☐ Yes (If yes, explain fully and provide inmate name(s), CDCR number(s) and institution(s), attach additional sheets, as needed).
4. Are you related to any inmate(s) at any CDCR institution? ☒ No ☐ Yes (If yes, explain fully and provide inmate(s) name(s), CDCR number(s) and institution(s) include additional sheets as necessary).

Volunteer Applicant: JANE STUDENT
Institution: CRC

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐ RENEWAL

SECTION II: To be Completed by CDCR Staff

Purpose of Entry (Circle specific program): ☐ Activity Group ☐ Religious

Name of Program: _____

Location of Volunteer Service (List institution and location, example: chapel, Facility A, classroom #, etc.): _____

Duration of volunteer service: (i.e., one, two or more months): _____

Day(s) of Week (Check): ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ Su Hours _____ Escort: ☐ No ☐ Yes

TB Test Required: ☐ No ☐ Yes (Annual TB Testing is required for all volunteers with more than 6 months of volunteer service)

Print Name/Classification _____

Signature _____

Date _____

COMMUNITY RESOURCES MANAGER

☐ Reviewed and submitted for background clearance

Signature _____

Date _____

CUSTODY STAFF

NLETS Cleared ☐ No ☐ Yes

NLETS Cleared Date: _____

☐ Needs further review

Signature _____

Date _____

WARDEN/WARDEN'S DESIGNEE SIGNATURE:

☐ APPROVED ☐ DISAPPROVED

Signature _____

Date _____

FOR USE BY CRM ONLY

GATE CLEARANCE ONLY ☐

Background clearance (NLETS) Date: _____

Live Scan Date/Location: _____

(Required after six months of volunteer service)

Verification of TB Test provided:

☐ Yes ☐ No ☐ N/A (if less than 6 months):

Date: _____

Copy of Volunteer Emergency Notification (CDC-894) sent to:

Control	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Watch Office	<input type="checkbox"/> No	<input type="checkbox"/> Yes

FOR USE BY PERSONNEL ONLY

VOLUNTEER IDENTIFICATION CARD (ID CARD) ☐

Title: **VOLUNTEER** (For all volunteer ID Cards)

Live Scan: _____

(Date/Location required after six months of volunteer service)

Date ID Card Issued: _____

ID Card Expiration Date: _____

Thumb Print Date: _____

ID Picture Date: _____

Copy of Volunteer Emergency Notification (CDC-894) sent to:

Control	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Watch Office	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Comments:

**PRIMARY LAWS, RULES, AND REGULATIONS REGARDING
CONDUCT AND ASSOCIATION WITH STATE PRISON INMATES
CDCR 181 (Rev.10/14)**

Individuals who are not employees of the California Department of Corrections and Rehabilitation (CDCR), but who are working in and around inmates who are incarcerated within California's institutions/facilities or camps, are to be apprised of the laws, rules and regulations governing conduct in associating with prison inmates, Title 15, Section 3225. The following is a summation of pertinent information when individuals not employed by the department (volunteers, media, contractors and their employees and dignitaries) come in contact with prison inmates.

1. Persons who are not employed by CDCR, but are engaged in work at any institution/facility or camp must observe and abide by all laws, rules and regulations governing the conduct of their behavior in associating with prison inmates. Failure to comply with these guidelines may lead to expulsion from CDCR institutions/facilities or camps.
SOURCE: California Penal Code (PC) Sections 5054 and 5058; California Code of Regulations (CCR), Title 15, Sections 3283, 3285, 3289, 3292 and 3415
2. CDCR does not recognize hostages for bargaining purposes. CDCR has a "NO HOSTAGE" policy and all prison inmates, visitors, non-employees and employees shall be made aware of this.
SOURCE: PC Sections 5054 and 5058; CCR, Title 15, Section 3304
3. All persons entering onto institution/facility or camp grounds consent to a search of their person, property or vehicle at any time. Refusal by individuals to submit to a search of their person, property or vehicle may be cause for denial of access to the premises or restrictions to visiting or facility access.
SOURCE: PC Sections 2601, 5054 and 5058; CCR, Title 15, Sections 3173, 3267, 3288, 3289, and 3292.
4. Persons normally permitted to enter an institution/facility or camp may be barred, for cause, by the CDCR Secretary, Director of Division of Adult Institutions (DAI), Warden, Regional Parole Administrator and /or their designees.
SOURCE: PC Sections 2086, 5054 and 5058; CCR, Title 15, Sections 3283 and 3289
5. It is illegal for an individual who has been previously convicted of a felony offense to enter into CDCR institutions/facilities or camps without the prior approval of the Warden. It is also illegal for an individual to enter onto these premises for unauthorized purposes or to refuse to leave said premises when requested to do so. Failure to comply with this provision could lead to prosecution.
SOURCE: PC Sections 602, 4570.5 and 4571; CCR, Title 15, Sections 3173, 3283 and 3289
6. Encouraging and/or assisting prison inmates to escape is a crime. It is illegal to bring firearms, deadly weapons, explosives, tear gas, drugs or drug paraphernalia on CDCR institutions/facilities or camp premises. It is illegal to give prison inmates firearms, explosives, alcoholic beverages, wireless communication devices or components thereof, tobacco products, narcotics, or any drug or drug paraphernalia, including cocaine or marijuana.
SOURCE: PC Sections 2772, 2790, 4535, 4550, 4573, 4573.5, 4573.6, 4574, 4576 and 5030.1; CCR, Title 15, Sections, 3172.1, 3188 and 3292
7. It is illegal to give or take letters from prison inmates without the authorization of the Warden. It is also illegal to give or receive any type of gift and/or gratuities from prison inmates.
SOURCE: PC Sections 2540, 2541 and 4570; CCR, Title 15, Sections 3010, 3399, 3401, 3424 and 3425
8. In an emergency situation the visiting program and other inmate program activities may be suspended by the Warden or designee.
SOURCE: PC Sections 2086 and 2601; CCR, Title 15, Section 3383
9. For security reasons, volunteers, media, contractors, dignitaries and guests must not wear clothing that in any way resembles state issued prison inmate clothing (blue denim shirts, blue denim pants).
SOURCE: CCR, Title 15, Sections 3174 and 3349.2.3(g) (3) (B)
10. Interviews with SPECIFIC INMATES are not permitted. Conspiring with an inmate to circumvent policy and/or regulations constitutes a rule violation that may result in appropriate legal action.
SOURCE: CCR, Title 15, Section 3261.5

I HEREBY CERTIFY AND ACKNOWLEDGE I HAVE READ THE ABOVE AND FULLY UNDERSTAND THE IMPLICATIONS REGARDING MY CONDUCT AND ASSOCIATION WITH CDCR INMATES. I ALSO UNDERSTAND VIOLATION OF ANY OF THE ABOVE COULD RESULT IN EXPULSION FROM A CDCR INSTITUTION/FACILITY OR CAMP WITH THE POSSIBILITY OF CRIMINAL PROSECUTION.

VOLUNTEER/MEDIA/CONTRACTOR/GUEST

NAME AND TITLE (Print)

JANE STUDENT

SIGNATURE

Jane Student

DATE SIGNED

TODAY'S DATE

DISTRIBUTION: Original – Warden, Parole Administrator and/or designee

Volunteer Applicant: JANE STUDENT
Institution: CRC

INSTITUTION USE ONLY

☐ NEW VOLUNTEER ☐ RENEWAL

5. Have you ever been arrested and/or convicted of any offense? ☒ No ☐ Yes *(If yes, list all detentions, arrests, and/or convictions. Attach additional sheet(s), if necessary.)*

Offense	Approx. Date	Disposition (Dismissed, Probation, Jail, Prison, etc.)	County	State	Country
"IF YES, PLEASE ADD INFO"					

6. Are you currently on parole or probation? ☒ No ☐ Yes *(If yes, shall be one year free of illegal activity, submit approval letter from RPA or designee, list name, telephone number and county of parole agent/probation officer)*

7. Are you discharged from prison or parole? ☒ No ☐ Yes *(If yes, shall be one year free of illegal activity, list date of discharge, name of institution, and attach letter addressed to the Warden outlining the circumstances below.)*

(If information is not disclosed or inaccurate information is provided, your application may not be approved)

I certify that:

- No salaries, wages, or unemployment benefits are to be paid for volunteer services.
- There is no Worker's Compensation provided.
- Use of State supplies may be permitted when directed to do so.
- I must attend any required training as directed.
- I have read and understand the CDCR Primary Laws, Rules, and Regulations Regarding Conduct and Association with State Prison Inmates (CDCR Form 181).
- I authorize CDCR to obtain information from law enforcement sources regarding my criminal history.
- I understand that I must notify the Community Resources Manager immediately in the event there is any change to any of the information I have provided.

The information you provide is entered and stored in a secure electronic database for a minimum of three years. By signing this application, you acknowledge and agree to this process.

Jane Student

Applicant's Signature

TODAY'S DATE

Date

VOLUNTEERS WITH DISABILITIES: If you have special requirements related to your disability (medical implants, prosthetic devices or requiring mobility assistive devices, i.e., crutches, walkers, braces, wheelchairs, battery operated or custom prescribed wheelchairs, guide dog for the visually or hearing impaired, insulin kit with syringes, etc.) you will need to attach a verifying statement from your physician. Volunteers with guide dogs will need to provide the dog's certification paperwork upon visit check-in. The CDCR will make every effort to provide reasonable accommodations for all qualified/eligible volunteers with disabilities in keeping with the safety and security of the institution and the public. If you have any questions and/or concerns, please contact the Community Resources Manager.

EMERGENCY NOTIFICATION INFORMATION
 CDCR 894 (Rev. 09/19)

Employees are responsible for ensuring this form is updated when changes occur. The person(s) to be notified in case of emergency should be over the age of 18.

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE): JANE STUDENT		LAST 4 DIGITS OF SOCIAL SECURITY NUMBER (FOR ID PURPOSES ONLY): 3410	
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE): 1234 SESAME STREET CLAREMONT, CA 91711			
HOME PHONE NUMBER: (800) 241-2211		WORK PHONE NUMBER: CELL PHONE NUMBER:	
INSTITUTION/FACILITY/PROGRAM AREA AND UNIT: CRC		PERSONAL EMAIL ADDRESS: jane.student@student.pitzer.edu	
PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)			
NAME (LAST, FIRST, MIDDLE): JOHN STUDENT		RELATIONSHIP: FATHER	
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE): 144 SUNNY LANE MODESTO, CA 92302			
HOME PHONE NUMBER: (222) 222-2222		WORK PHONE NUMBER: CELL PHONE NUMBER:	
ALTERNATE PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)			
NAME (LAST, FIRST, MIDDLE): JAMIE STUDENT		RELATIONSHIP:	
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE): 144 SUNNY LANE MODESTO, CA 92302			
HOME PHONE NUMBER: (333) 333-3333		WORK PHONE NUMBER: CELL PHONE NUMBER:	
MEDICAL INFORMATION			
PERSONAL PHYSICIAN'S NAME: DR. LARA BLACK		PHONE NUMBER: (000) 000-0000	
MEDICAL PLAN NAME: KAISER-HMO	MEDICAL PLAN CARD NUMBER: 555555	MEDICAL FACILITY NAME AND LOCATION: KAISER PERMANENTE-FONTANA	
SPECIAL MEDICAL CONDITIONS (ALLERGIES, ETC.): NONE			
SPECIAL INSTRUCTIONS:			
EMPLOYEE'S SIGNATURE: <i>Jane Student</i>		DATE: TODAY'S DATE	

This information will be kept confidential and used for emergencies only. This form will be filed in your Official Personnel File (OPF) and in the supervisory file.

DISTRIBUTION Original: OPF Copy: Supervisor File

PERSONNEL OFFICE USE	
REVIEWER'S PRINTED NAME:	
BIS KEY DATE:	PHONE NO.:

EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION

CDCR 7336 (Rev. 03/20)

Page 1 of 2

Confidential Employee Medical Information

INSTRUCTIONS: Tuberculosis (TB) screening must be performed by a licensed health care provider whose legally authorized scope of practice allows them to conduct medical examinations and/or the Mantoux TST in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) to determine if a person has TB infection or disease.

Employee (Complete Section 1. Type or print clearly.)

Section 1 Employee Information		
Employee Full Name (First, MI, Last) <i>JANE STUDENT</i>		Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Non-binary
Birthdate (MM/DD/YYYY) <i>02/01/2004</i>	PERNR <i>—</i>	New Employee/Cadet? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Institution/Facility/Program <i>CRC</i>	Unit/Location	Department (If not CDCR)
Employee Signature <i>Jane Student</i>		Date <i>TODAY'S DATE</i>

Health Care Provider (Complete Sections 2–7, as required. See instructions on Page 2 of 2.)

Section 2 TB History and Treatment (Private providers, please attach documentation of prior history.)	
History of treatment of TB infection or disease: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>If yes, complete Section 6.</u>	
Date of results of previous TST: _____ Induration _____ mm <input type="checkbox"/> Not applicable	
Date and results of previous Interferon-Gamma Release Assay (IGRA): _____ <input type="checkbox"/> Not applicable	
Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, type of drug prescribed: _____ Start and stop dates of drug: _____	

Notice: HIV and other medical conditions may cause a TST to be negative when TB infection is present.

Section 3 Tuberculin Skin Test (TST) Administration			
TST <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Tubersol Lot #: <i>B7581AA</i> <input type="checkbox"/> Aplisol Expiration Date: <i>6/3/24</i>	TST Administered By (Print Name) <i>JOHNNY DONUT</i>	Signature <i>Johnny Donut</i>
Injection Site <input type="checkbox"/> Left Forearm (LFA) <input checked="" type="checkbox"/> Right Forearm (RFA)	Injection Date and Time <i>6/13/22 @ 1130</i>	Interpretation <input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	TST Result <i>NEG</i> Induration: _____ mm
		Date and Time of Symptom Evaluation <i>6/16/22 @ 935 am</i>	

Section 4 TB Blood Test			
TB Blood Test <input type="checkbox"/> Yes <input type="checkbox"/> No	TB Blood Draw Date and Time	TB Blood Test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date and Time of Results
TB Blood Test Administered By (Print Name)		Signature	Date

Section 5 Evaluation for Signs and Symptoms (Complete for all individuals.)			
<input checked="" type="checkbox"/> No Symptoms	Symptoms (Check all that apply) <input type="checkbox"/> Persistent Cough (>2 Weeks) <input type="checkbox"/> Unexplained Fever <input type="checkbox"/> Unexplained Night Sweats <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Unexplained Fatigue <input type="checkbox"/> Other: _____		

Section 6 Chest X-Ray (Complete for all positive TB test results, as required by the CDC.)	
Chest X-ray Report <input type="checkbox"/> On File <input type="checkbox"/> Copy Attached <input type="checkbox"/> Chest X-Ray Needed	Chest X-Ray Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Consistent with TB

Section 7 Evaluation	
<input type="checkbox"/> Employee Referred for Follow-Up Medical Evaluation <input type="checkbox"/> Employee Provided Written Notification of TB Screening Results	
Comments:	
<input checked="" type="checkbox"/> EMPLOYEE IS FREE OF INFECTIOUS TUBERCULOSIS	

Licensed Evaluator (Print Name) <i>JOHNNY DONUT</i>	License Number <i>108222</i>	Licensed Evaluator Signature <i>Johnny Donut</i>	Date <i>6/16/22</i>
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EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION**CDCR 7336 (Rev. 03/20)**

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The California Penal Code, Section 6006 et seq., requires all California Department of Corrections and Rehabilitation (CDCR) employees and certain other individuals to have an initial, annual, and as medically necessary, Mantoux Tuberculin Skin Test (TST) or evaluation. The testing must occur as instructed below. The employee must provide the results of the TST or Tuberculosis (TB) blood test and evaluation on the required Employee Tuberculin Skin Test (TST) and Evaluation (CDCR 7336) form.

Definitions:

- **Induration:** Swelling or raised skin. **Note:** The presence of erythema is NOT indicative of a TST reaction; only the induration is measured.
- **Mantoux TST:** Intradermal injection of 0.1 milliliters (ml) of Purified Protein Derivative, 5 Tuberculin Units (TU).
- **Prior TST:** A Mantoux TST in which clearly documented and dated results are available in millimeters (mm).
- **Negative TST Result:** Induration of less than (<) 10 mm if new, or < 5 mm, if contact or known immunocompromised.
- **Positive TST Result:** Induration equal to or greater than (>) 10 mm, OR > 5 mm if contact or known immunocompromised.

CDCR Health Care Providers (HCP) shall not ask CDCR employees about non-TB health history, including immunosuppressive conditions.

The Centers for Disease Control and Prevention (CDC) and the California Tuberculosis Controllers Association recommend the following:

1. The tine test is NOT an acceptable skin test to determine exposure to the TB bacillus. The only acceptable screening methods for detecting TB infection are TB screening tests that are licensed by the Federal Food and Drug Administration (FDA) and recommended by the CDC.
2. A chest X-ray (CXR) cannot be used to definitively diagnose TB. However, a CXR may be used to rule out the possibility of pulmonary TB in a person who has had a positive reaction to a TST or TB blood test and no symptoms of disease.
3. The process for administering, evaluation, and documenting the Mantoux TST are:
 - a) Must be given intradermally.
 - b) 0.1 ml (s) of 5 TU Purified Protein Derivative must be used.
 - c) The test must be interpreted by a qualified HCP.
 - d) Results must be documented in mm(s) of induration.

Instructions: Employee**Section 1: Complete all items in Section 1.**

- Provide accurate and complete information.
- Ensure the health care provider(s) (HCP) administering and evaluating the TST, including the exam for TB signs and symptoms, completes, signs, and dates the form.
- Advise the HCP to follow the steps below when completing Sections 2 through 7.
- If a CXR is needed, you are required to submit a copy of the CXR report with this form for clearance to be placed in your health record.
- Submit the completed Employee Tuberculin Skin Test (TST) and Evaluation (CDCR 7336) form, in a sealed envelope.

Instructions: Health Care Provider (HCP)**Section 2: Complete Section 2, if applicable.**

Complete this section if prior TST or TB blood test results and treatment are available. The employee or HCP must provide written documentation including the date test was administered, reaction in mm or IGRA, treatment, and drug administered (if any) start and stop dates.

If documented results are:

- **NEGATIVE** and more than 30 days old, proceed to Section 3.
- **NEGATIVE** and less than 30 days old, proceed to Section 5.
- **POSITIVE** on any date, complete Sections 5, 6, and 7.

If there are no appropriately documented prior TST or TB blood test results, continue to Section 3.

Section 3: Administer a new TST and document the test results in Section 3. The HCP administering the TST in Section 3 must sign and date the appropriate blocks. The block identified as "Date and Time of Results" refers to date the employee's TB status is determined.

If documented results are:

- **NEGATIVE**, complete Sections 5 and 7.
- **POSITIVE**, complete Sections 5, 6, and 7. A copy of CXR report must be attached for all **POSITIVE** results.

Section 4: Administer a new TB blood test and document the test results in Section 4. The HCP administering the TB blood test must sign and date the appropriate blocks. The block identified as "Date and Time of Results" refers to date the employee's TB status is determined.

If documented results are:

- **NEGATIVE**, complete Sections 5 and 7.
- **POSITIVE**, complete Sections 5, 6, and 7. A copy of CXR report must be attached for all **POSITIVE** results.

If an individual claims to have a prior positive TB blood test or TST, but is unable to provide appropriate documentation, a TST or TB blood test must still be administered. This is not medically contraindicated. However, a diluted TST may be administered by the following method: dilute 0.2 cc of the standard 5 TU/0.1cc solution with 0.8 cc of sterile saline; use 0.1 of the solution to administer the TST. **Note:** This is not a CDCR procedure. If the results are positive, no further testing is necessary. If the administered or documented TB blood test shows a negative result, the employee most likely does not have the TB infection. Factors affecting the immune system, pregnancy, or recent TB infection may cause a false negative TST or TB blood test reaction, even when TB disease exists. If the TB blood test or TST indicates a positive reaction, further medical evaluation and a CXR are required to rule out active TB disease.

Section 5: Complete the evaluation for all employees. Three or more symptoms warrant special concern.

Section 6: Complete this section for individuals with a prior documented or newly significant TST or TB blood test. If a prior CXR report is on file, attach a copy of the CXR report to this form and mark the applicable results. If the individual does not have CXR report on file, administer a CXR, attach a copy of the report, and check the applicable results. The CXR report is required by CDC.

Section 7: The HCP, Physician, Surgeon or licensed designee evaluating for TB signs and symptoms must complete this section. Evaluators may note comments, as necessary. Check the box if the employee is free of infectious TB, print name, enter license number, sign, and date this section.

After evaluation or treatment, provide the original completed and signed CDCR 7336 form to the employee for return to CDCR.

TB INFECTION FREE STAFF CERTIFICATION

CDCR 7354 (Rev. 07/15)

Page 1 of 2

Applicants, current employees, volunteers and employees from other state agencies who work in the California Department of Corrections and Rehabilitation (CDCR) facilities or with CDCR inmates (as defined in Penal Code Section 6006 et seq.) are required to be evaluated for tuberculosis (TB) and certified to be free of TB in an infectious or contagious stage prior to assuming duties with CDCR, and at least annually thereafter. Evaluation shall be done by a licensed physician and surgeon or his/her licensed designee whose legally authorized scope of practice he allows him/her to conduct examinations for TB under physician supervision; in accordance with the most current recommendations of the Centers for Disease Control and Prevention. Certificates shall be submitted to and maintained by CDCR.

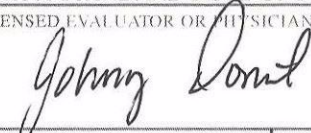
CERTIFIED TO BE FREE OF INFECTIOUS TB

PATIENT FULL NAME AS IT APPEARS ON STATE PAYCHECK (TYPE OR PRINT CLEARLY)	BIRTHDATE (FOR IDENTIFICATION PURPOSES ONLY)
JANE STUDENT	02/01/2004

I, JOHNNY DONUT _____ a physician and
PRINT OR TYPE PHYSICIAN NAME AND TITLE

surgeon licensed by the Medical Board or Osteopathic Medical Board of California, or my licensed designee, have
*evaluated the patient, identified above, and **CERTIFY** he/she is free of tuberculosis in an infectious or contagious stage.

(* IF EVALUATION INCLUDES A TB SKIN TEST [PREFERRED, AND REQUIRED IF NEITHER WRITTEN MM OR BLOOD TEST
DOCUMENTATION OF A PRIOR POSITIVE NOR CURRENT TB BLOOD TEST RESULTS], THE MANTOUX INTRADERMAL METHOD
WITH A STANDARD DOSE OF PURIFIED PROTEIN DERIVATIVE MUST BE USED.)

LICENSED EVALUATOR OR PHYSICIAN SIGNATURE (AS APPROPRIATE)	DATE	TELEPHONE NUMBER
	6/16/22	(221) 111-1111
LICENSED EVALUATOR NAME AND TITLE IF DIFFERENT FROM ABOVE (PRINT)		
LICENSE #	ADDRESS	
108222	3900 E. PCH CLAREMONT, CA 91711	

TB INFECTION-FREE STAFF CERTIFICATION

CDCR 7354 (Rev. 07/15)

NOTICE TO PHYSICIANS

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CONFIDENTIAL EMPLOYMENT MEDICAL INFORMATION

DEFINITIONS:

PHYSICIAN AND SURGEON: An individual licensed by either the Medical Board of California or the Osteopathic Medical Board of California.

LICENSED DESIGNEE: An individual who the physician and surgeon designates to conduct the required examination in his/her place, and whose legally authorized scope of practice allows him/her to conduct examinations for TB under physician supervision.

INSTRUCTIONS: EMPLOYEE

Complete the top portion of the form; clearly print your legal name and BIRTHDATE (FOR THE IDENTIFICATION PURPOSE ONLY).

INSTRUCTION: HEALTHCARE PROVIDER

After completing the required examination (as directed on the back of the CDCR Form 7336 "Employee TST and Evaluation"), and completing and signing that form;

- Print the name and title of the supervising physician where indicated.
- The physician or designated evaluator (whoever completes the examination) should sign in the appropriate box. If a designated evaluator, complete the boxes "Evaluator Name and Title, License #"
- Date the form; complete the boxes for the telephone number and address.

DISTRIBUTION: ORIGINAL- EMPLOYEE MEDICAL FILE. CANARY- EMPLOYEE

CERTIFICATION OF VOLUNTEER PARTICIPATION

CDCR 1049 (Rev. 08/08)

To be completed by the volunteer's supervisor/sponsor at completion of the volunteer service agreement or termination.


Please Print

Volunteer Name: JANE STUDENT		Supervisor/Sponsor Name:	
Address: 1234 SESAME STREET #143 CLAREMONT, 91711		Institution/Headquarters/Parole Unit:	
		Telephone Number:	Unit/Division:
Telephone Number (Home): (800) 241-2211	Telephone Number (Work):	Area Where Volunteer Provided Service:	

Describe duties performed: special skills/credentials held, equipment or tools used.

INSIDE OUT STUDENTLength of Service: FROM: CLASS, START, DATE TO: CLASS, END DATEDid the volunteer supervise inmates? Yes ☐ No ☒ If Yes, how many _____Performance Rating: Excellent ☐ Good ☐ Needs improvement ☐ Unsatisfactory ☐

If dismissed, give reason:


VOLUNTEER'S SIGNATURE

TODAY'S DATE
DATE SIGNED

SUPERVISOR/SPONSOR'S SIGNATURE

DATE SIGNED

DISTRIBUTION: ORIGINAL - Volunteer; CANARY - File; PINK - Supervisor

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT

CDCR 8019 (06/20)

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CANDIDATE/EMPLOYEE INFORMATION

Name (Print First and Last) <i>JANE STUDENT</i>	Institution/Facility/Program <i>CRC</i>
Check one:	
<input type="checkbox"/> Applying for a position.	Proposed classification:
<input type="checkbox"/> Reporting a relationship.	Current classification:
<input checked="" type="checkbox"/> Other:	Current classification:

Department Operations Manual (DOM) Section 33010.25, Nepotism and Fraternization

The Department has established policies to counteract nepotism and fraternization in the workplace.

(a) Policy

It is the policy of CDCR to recruit, hire, and assign all employees on the basis of merit and fitness in accordance with civil service statutes, rules, and regulations. This policy is intended to uphold the merit principle of civil service by preventing and prohibiting preferential treatment or bias due to personal relationships. Nepotism is antithetical to a merit-based personnel system and staff shall not use their personal relationships to aid or hinder others in the employment setting. CDCR reserves the right to initiate mandatory reassignments, employee transfer, or take other administrative action to avoid or correct situations where the potential for employment decisions based on nepotism exists.

(b) Personal Relationship Defined

For purposes of this section, personal relationships include, but are not limited to, an association with another individual by blood, adoption, foster arrangement, cohabitation, current or previous marriages (including in-laws), registered domestic partnership, or romantic relationships.

(c) Hiring Authority, Manager, or Supervisor Responsibilities

The hiring authority, managers, or supervisors must ensure their candidates and employees are aware of the departmental nepotism and fraternization policy, including reporting requirements. The hiring authority, manager, or supervisor shall consider the nepotism and fraternization policy prior to making employment decisions. The hiring authority, manager, or supervisor must inform candidates of the nepotism and fraternization policy at the time of interview. As part of the interview process for any position, regardless of whether the candidate is a current employee, each candidate shall be required to sign a CDCR Form 8019, Nepotism and Fraternization Policy Acknowledgement form to confirm their understanding of this policy. In addition, the hiring authority, manager, or supervisor must take appropriate action to correct violations of this policy. The hiring authority, manager, or supervisor is responsible for requesting an exception/appeal to the policy if necessary (refer to Exception/ Appeal Procedures below). Exceptions/appeals to the policy may be granted under limited circumstances.

(d) Employee Responsibilities

- (1) Upon hire employees shall complete and submit a CDCR Form 8019 to their hiring authority, manager, or supervisor.
- (2) Employees shall immediately notify the hiring authority or their respective supervisor when an employment decision is in conflict with the departmental nepotism and fraternization policy. It is the employee's responsibility to read and adhere to the nepotism and fraternization policy.

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT
CDCR 8019 (06/20)**(e) Employment Settings**

- (1) Employment settings refer to the working relationships of employees and their supervisors. Employees involved in personal relationships may work in the same program, section, or unit as the person with whom they have a personal relationship, however, in accordance with applicable state employment laws and collective bargaining agreements employment settings shall not exist where an employee would:
 - (A) Work for the same first-line supervisor as the person with whom they have a personal relationship.
 - (B) Have a direct (first line supervisor), or indirect (second line supervisor) supervisory relationship as the person with whom they have a personal relationship.
 - (C) Work under a hiring authority with whom they have a personal relationship, regardless of departmental separation.

(f) Employment Decisions

- (1) Employment decisions refer to the full array of assessments and actions that involve CDCR and employees and their employment. Employees involved in personal relationships may work in the same program, section, or unit as the person with whom they have a personal relationship, however, employment decisions shall not be made where an employee involved in a personal relationship would:
 - (A) Audit the work of, or exercise fiscal control over a person with whom they have a personal relationship, regardless of organizational separation.
 - (B) Hire, promote, transfer, or approve an out-of-class, or re-assignment of a person with whom they have a personal relationship.
 - (C) Participate in the selection process, including assisting with the development of screening criteria and/or interview questions, or serve on a hiring panel of a person with whom they have a personal relationship.
 - (D) Develop, administer, or rate a civil service examination of a person with whom they have a personal relationship.
 - (E) Initiate an administrative investigation or be involved in the discipline process of a person with whom they have a personal relationship.
 - (F) Assign work to a person with whom they have a personal relationship, except in a rare emergency situation.
 - (G) Prepare, conduct, or contribute information on a performance appraisal of a person with whom they have a personal relationship.
 - (H) Approve overtime or any other compensated time/pay of a person with whom they have a personal relationship, when it is on a voluntary basis and another supervisor is available.
 - (I) Approve vacation, sick, or any other type of leave of a person with whom they have a personal relationship, when another supervisor is available.
 - (J) Grant or deny permission to attend a conference or other work-related event of a person with whom they have a personal relationship.
 - (K) Approve reimbursement for work related expenses of a person with whom they have a personal relationship.
 - (L) Adversely affect or influence the safety, security, or morale of employees of a program, section, or unit.
 - (M) Adversely affect or influence the fair and impartial supervision and evaluation of employees.

(g) Exception/Appeal Procedures

- (1) When the employment setting or employment decision violates the departmental nepotism and fraternization policy, the hiring authority, manager, or supervisor shall request and receive approval prior to making an employment decision. Actions to remediate noncompliance may include an involuntary transfer of employees, in accordance with applicable state employment laws and collective bargaining agreements. Under no circumstances should an employee participate in the defined employment decisions with an employee, applicant, or candidate with whom they have a personal relationship.
- (2) The exception/appeal procedures are as follows:
 - (A) A written request shall be submitted through the immediate manager or supervisor to the hiring authority, which clearly defines the personal relationship, and the benefit(s) to the State that an exception/appeal would provide (e.g., overcoming a recruitment difficulty or obtaining a uniquely skilled person).
 1. For CDCR: Exception/appeal requests involving the hiring authority (Regional Administrator, Deputy Director, Superintendent, etc.) shall be submitted to the next higher level within the hiring authority's chain of command or equivalent, and then to the applicable second higher level within the hiring authority's chain of command or equivalent to render a decision.
 2. For CDCR: Exception/appeal requests involving the Warden shall be submitted to the applicable Associate Director or equivalent, then to the applicable Deputy Director or equivalent, and then to the applicable Director or equivalent to render a decision.

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT

CDCR 8019 (06/20)

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3. For CCHCS: Exception/appeal requests involving the hiring authority shall be submitted to the next level within the hiring authority's chain of command. All exception/appeal requests shall be reviewed by the CCHCS Office of Legal Affairs via the Deputy Director, Human Resources, to render a decision.
- (B) Each exception/appeal request shall be reviewed to assess the potential for, and degree of impact upon the following:
1. Safety, security, and morale of the employees in the program, section, or unit.
 2. Fair and impartial supervision and evaluation of the employee by the supervisor in the program, section, or unit.
 3. Basis of merit and fitness in accordance with civil service statutes, rules, and regulations.
- (C) A written response to the exception/appeal request will be completed within ten (10) working days.
1. If the exception/appeal request is approved, a copy of the approved document(s) shall be forwarded to the appropriate personnel officer. The personnel officer shall place a copy of the approval document(s) in the hiring and recruitment package and in the respective employee's official personnel file.
 2. If an exception/appeal is granted, there shall not be any employment decisions made by the related employees. Another manager or supervisor shall be responsible for employment decisions except in an extremely rare documented circumstance.
 3. If the exception/appeal request is denied, a written explanation of the basis for the denial, shall be provided to the candidate or employee. A copy of the denial document(s) shall be forwarded to the appropriate personnel officer. The personnel officer shall place a copy of the denial document(s) in the hiring and recruitment package, and if applicable, into the respective employee official personnel file. Every effort shall be made to avoid relocation expenses. If an employee must relocate to meet the Department's nepotism and fraternization policy, the Department shall pay any associated relocation expenses. (Refer to the CalHR Rules and Regulations.)

(h) Retention

All Nepotism and Fraternization forms, and any exception/appeal approvals or denials, shall be forwarded to the personnel officer for filing in either the official personnel file or the hiring and recruitment file.

CANDIDATE/EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have read and understand the nepotism and fraternization policy as stated in DOM Section 33010.25, Nepotism and Fraternization.

Check one:

☒ I do not have any relative(s) or person(s) with whom I have a personal relationship employed by CDCR.

☐ I have the following relative(s) or person(s) with whom I have a personal relationship employed by CDCR. If checked, complete the information below. Use the back of this form if additional space is needed.

Name	Relationship	Institution/Program/Section/Unit	Classification
1.			
2.			
3.			
Signature <i>Jane Student</i>		Date <i>TODAY'S DATE</i>	

NEPOTISM AND FRATERNIZATION POLICY ACKNOWLEDGEMENT
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HIRING AUTHORITY, MANAGER, OR SUPERVISOR INFORMATION

Name (Print First and Last) JANE STUDENT	Classification
Review DOM Section 33010.25 to determine whether the personal relationship(s) listed above are in conflict with the nepotism and fraternization policy.	
Check one:	
<input checked="" type="checkbox"/> No conflict.	
<input type="checkbox"/> Conflict: Relationship #1: <input type="checkbox"/> Relationship #2: <input type="checkbox"/> Relationship #3: <input type="checkbox"/> All Relationships: <input type="checkbox"/> Submit this form with a written request for exception/appeal to the hiring authority or designee.	
Signature	Date

HIRING AUTHORITY OR DESIGNEE INFORMATION

Name (Print First and Last)	Classification
Review DOM Section 33010.25 to determine whether an exception/appeal to the nepotism and fraternization policy is approved or denied.	
Check one:	
<input type="checkbox"/> Exception/appeal approved.	
<input type="checkbox"/> Exception/appeal denied. State the reason for denial:	
Signature	Date

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART A
CDCR 2301 (Rev. 05/20)

Page 1 of 3

The Prison Rape Elimination Policy for the California Department of Corrections and Rehabilitation (CDCR) is explained on this informational sheet. As a volunteer or private contractor who has contact with CDCR offenders, it is your responsibility to do what you can, within the parameters of your current assignment, to reduce incidents of sexual violence, staff sexual misconduct, and sexual harassment and to report information appropriately when they are reported to you or when you observe such an incident. For purposes of this Policy, the word "staff" includes volunteers and private contractors.

Historical Information

Both the Congress and State Legislature passed laws, the Federal Prison Rape Elimination Act (PREA) of 2003, the Sexual Abuse in Detention Elimination Act, Chapter 303, Statutes of 2005, and most recently the United States, Department of Justice Final Rule; National Standards of 2012 to help prevent, detect, and respond to sexual violence, staff sexual misconduct, and sexual harassment behind bars. It is important that we, as professionals, understand all aspects of these laws and our responsibilities to help prevent, detect, and respond to instances by offenders and staff.

CDCR Policy

The CDCR policy is found in Department Operations Manual (DOM), Chapter 5, Article 44. PREA addresses five types of sexual offenses. Sexual violence committed by offenders against offenders encompasses: abusive sexual contact, non-consensual sex acts, and sexual harassment by an offender. Other sections covered by PREA include staff sexual misconduct towards an offender and staff sexual harassment towards an offender.

CDCR's policy provides for the following:

- CDCR is committed to continuing to provide a safe, humane, secure environment, free from offender on offender sexual violence, staff sexual misconduct, and sexual harassment.
- CDCR maintains zero tolerance for sexual violence, staff sexual misconduct, and sexual harassment in its institutions, community correctional facilities, conservation camps, and for all offenders under its jurisdiction.
- All sexual violence, staff sexual misconduct, and sexual harassment is strictly prohibited.
- This policy applies to all offenders and persons employed by the CDCR, including volunteers and independent contractors assigned to an institution, community correctional facility, conservation camp, or parole.

Retaliatory measures against employees or offenders who report incidents of sexual violence, staff sexual misconduct, or sexual harassment as well as retaliatory measures taken against those who cooperate with investigations shall not be tolerated and shall result in disciplinary action and/or criminal prosecution. Retaliatory measures include, but are not limited to:

- Coersion.
- Threats of punishments.
- Any other activities intended to discourage or prevent staff or offenders from reporting incident(s).

Professional Behavior

Staff, including volunteers and private contractors are expected to act in a professional manner while on the grounds of a CDCR institution and while interacting with other staff and offenders. Key elements of professional behavior include:

- Treating everyone, staff and offenders alike, with respect.
- Speaking without judging, blaming, or being demeaning.
- Listening to others with an objective ear and trying to understand their point of view.
- Avoiding gossip, name calling, and what may be perceived as offensive or "off-color" humor.
- Taking responsibility for your own behavior.

Preventative Measures

You can help reduce sexual violence, staff sexual misconduct, and sexual harassment by taking various actions during the performance of your duties as a volunteer or private contractor.

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART A

CDCR 2301 (Rev. 05/20)

Page 2 of 3

The following are ways in which you can help:

- Know and enforce the rules regarding the sexual conduct of offenders.
- Be professional at all times.
- Make it clear that sexual activity is not acceptable.
- Treat any suggestion or allegation of sexual violence, staff sexual misconduct, and sexual harassment as serious.
- Follow appropriate reporting procedures and assure that the alleged victim is separated from the alleged predator.
- Never advise an offender to use force to repel sexual advances.

Detection

All staff, including volunteers and private contractors, is responsible for reporting immediately and confidentially to the appropriate supervisor any information that indicates an offender is being, or has been, the victim of sexual violence, staff sexual misconduct, or sexual harassment.

After immediately reporting to the appropriate supervisor, you are required to document the information you reported. You will be instructed by the supervisor regarding the appropriate form to be used for documentation.

You will take necessary action (i.e., give direction or press your alarm) to prevent further harm to the victim. Staff, including volunteers and private contractors, will request the victim does not: 1) Shower; 2) Remove clothing without custody supervision; 3) Use the restroom facilities; and 4) Consume any liquids.

I have read the information above and understand my responsibility to immediately report any information that indicates an offender is being, or has been, the victim of sexual violence, staff sexual misconduct, or sexual harassment.

JANE STUDENT

Volunteer/Contractor Name (Printed)

Jane Student

Signature of Volunteer/Contractor

(900) 241-2211

Contact Telephone Number

Date Signed_____
Current Assignment within Institution_____
Supervisor in Current Assignment

PREA POLICY INFORMATION FOR VOLUNTEERS AND CONTRACTORS PART B

CDCR 2301 (Rev. 05/20)

Page 3 of 3

PART B shall only be completed by contractors who, in the course of their assigned duties, have contact with inmates.**Duty to Report**

You are required to answer the following questions:

- 1) Have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, other institution?
☐ Yes ☒ No If yes, provide the date of the incident and the facility name in the space below.
- 2) Have you ever been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?
☐ Yes ☒ No If yes, provide the date of the incident and the county in the space below.
- 3) Have you ever been civilly or administratively found to have engaged in the activity described in question (2) above?
☐ Yes ☒ No If yes, provide the date of the incident and the county in the space below.
- 4) Have you ever received any disciplinary action as a result of allegations of sexual harassment of an inmate in a prison, jail, lockup, community confinement facility, or other institution?
☐ Yes ☒ No If yes, provide the date of the incident and the facility name in the space below.

If you answered "Yes" to any of the questions, please provide the date of the incident and the facility name/county where it occurred:

Date: TODAY'S DATEFacility/County Name: CRC

As a contract employee, you have a continuing duty to promptly report, and you are required to notify your employer and the Appointing Authority of the Institution to which you are assigned if the answer to any of the above questions changes.

I hereby certify that there are no misrepresentations, omissions, or falsifications, and that all answers are true and correct. I understand and agree that if any material facts are discovered which differ from those facts stated by me on this form, my services to the California Department of Corrections and Rehabilitation will be discontinued and my contract employer will be notified.

Printed Name:

JANE STUDENT

Signature:

Jane Student

Date:

TODAY'S DATE

ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

APPLICANT INFORMATION

LAST NAME STUDENT		FIRST NAME JANE	SOCIAL SECURITY NUMBER	GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE
ADDRESS 1234 SESAME STREET #143			CITY CLADEMONT	STATE CA ZIP CODE 91211
DAYTIME TELEPHONE (800) 241-2211	EVENING TELEPHONE	CLASSIFICATION	HIRING DEPARTMENT	

CONTACT INFORMATION

NAME PROFESSOR'S NAME	TITLE
LOCATION	TELEPHONE PROFESSOR'S PHONE NO.

LIST OF ESSENTIAL FUNCTIONS

Enter list of essential functions of the job from current duty statement here, or attach duty statement:

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by a volunteer to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Standing: Frequently - stands while speaking with inmates, staff, and other volunteers.

Walking: Occasionally - walks to and from parking area, to gate, to the various facilities to perform services/programs.

Sitting: Frequently - sits during programs. There is flexibility for movement on a frequent basis to break sitting with standing and walking.

Lifting: Occasionally - occasionally lift paperwork/files/materials for program/service.

Carrying: Occasionally - carries paperwork, files and materials for short distances.

Bending/Stooping: Occasionally - bending/stooping occurs when picking up paperwork/files/materials and loading/unloading them from vehicles. Slight bending at the waist and neck occurs on a frequent basis throughout the day.



Reaching in Front of Body: Frequently - placing items on and retrieving items from waist/shoulder level tables.

Climbing: Occasionally - climbs steps throughout the institution in order to get to program space.

Pushing/Pulling: Occasionally may push and pull on binders, equipment, supplies, books as needed.

ACKNOWLEDGEMENT

I certify that the duties listed above represent the essential functions of the job and classification listed above.

SUPERVISOR'S NAME	SUPERVISOR'S SIGNATURE 	DATE
PERSONNEL OFFICER'S NAME	PERSONNEL OFFICER'S SIGNATURE 	DATE

ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

APPLICANT'S CERTIFICATION OF ESSENTIAL FUNCTIONS

I certify that I have read the essential functions of the job listed on page 1 and considering my current health status (please check one of the boxes below):

- ☒ I am able to perform all of the essential functions of the job without a need for reasonable accommodation.
- ☐ I am able to perform all of the essential functions of the job, but will require reasonable accommodation (please describe your requested accommodation in the Reasonable Accommodation section below).
- ☐ I am unable to perform one or more of the essential functions of the job, even with reasonable accommodation.
- ☐ I am not sure if I am able to perform one or more of the essential functions of the job. I have identified the functional limitations that I believe may limit my ability to perform the essential functions of the job in the Request for Essential Functions Evaluation section below.

REASONABLE ACCOMMODATION (If necessary, you may attach additional pages)

For each essential function of the job for which you require reasonable accommodation, please describe the reasonable accommodation you are requesting:

REQUEST FOR ESSENTIAL FUNCTIONS EVALUATION (If necessary, you may attach additional pages)

I am not sure whether I have a physical or mental limitation that may prevent or otherwise impair me from performing the essential functions of the job. Below I have listed the essential functions in question and my specific functional limitations that I believe may prevent or otherwise impair me from performing the listed essential functions of the job. I authorize the hiring authority, if necessary, to refer this information to the State Personnel Board's Medical Officer, or his/her delegate, to determine my ability to perform the essential functions of the job with or without reasonable accommodation.

ACKNOWLEDGEMENT

I certify that the information I have provided concerning my ability to perform the essential functions of the job is true and complete to the best of my knowledge.

APPLICANT'S NAME (Print or type)

JANE STUDENT

APPLICANT'S SIGNATURE

Jane Student

DATE

TODAY'S DATE



HEALTH CARE SERVICES



CERTIFICATE OF COMPLETION

This certificate acknowledges that

Name _____

has successfully completed

Communicable Disease Prevention - NEO

Employee PERNR

50

Credits/Hours



Today's Date

Date of Completion

One year from the date of completion

Certificate Expiration Date



HEALTH CARE SERVICES



CERTIFICATE OF COMPLETION

This certificate acknowledges that

Student Name

has successfully completed

Emergency Operations Plan for Institutions - NEO

Employee PERNR

1 00

Credits/Hours



Today's Date

Date of Completion

One year from the date of completion

Certificate Expiration Date



HEALTH CARE SERVICES



CERTIFICATE OF COMPLETION

This certificate acknowledges that

Name _____

has successfully completed

Inmate/Staff Relations - NEO

Employee PERNR

50

Credits/Hours



Today's Date

Date of Completion

One year from the date of completion

Certificate Expiration Date



HEALTH CARE SERVICES



CERTIFICATE OF COMPLETION

This certificate acknowledges that

Name

has successfully completed

EEO Sexual Harassment Prevention Non-Supervisory - NEO

Employee PERNR

1 00

Credits/Hours



Today's Date

Date of Completion

One year from the date of completion

Certificate Expiration Date

Fire and Life Safety Quiz

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures as defined in the Fire and Life Safety Module that I received. Please contact your immediate supervisor if you have additional questions.

PERNR # LEAVE BLANK

Signature: SIGN

Print Name: PRINT

Date: TODAY'S DATE

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures as defined in the PREA OJT Module that I received. Please contact your immediate supervisor if you have additional questions.

PERNR # LEAVE BLANK

Signature: _____

Print Name: _____

Date: _____

Tuberculosis Testing
Lesson Acknowledgement and Signature

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures as defined in the Tuberculosis Testing OJT Module that I received.

Please contact your immediate supervisor if you have additional questions.

PERNR # LEAVE BLANK

Signature: _____

Print Name: _____

Date: _____

**Information Practices Act
Lesson Acknowledgement and Signature**

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures as defined in the Information Practices Act OJT Module that I received.

Please contact your immediate supervisor if you have additional questions.

PERNR # LEAVE BLANK

Signature: _____

Print Name: _____

Date: _____