Osan VP Volunteers/ Coaches Cover Sheet

1. Make sure that ALL coach/volunteer signature blocks are signed.

2. Make sure the coach/volunteer cover sheet bases are listed (if overseas, the previous PSC mailing address is needed; if stateside the previous stateside mailing address is needed).

3. Make sure that on ALL applications for the address block; you use the PSC address.

NAME: ________________________ SSN: _____________________

DEROS: ______________________

Please indicate:

Active Duty-Rank: ____________ Civilian

Please provide the following information below:

Bases/installations you have lived In the past 2 *YEARS*	
Base Name	Mailing address at that base
1.	
2.	
3.	
4.	

Please drop off the completed packet at Bldg. 936 Rm 112 (NAF Human Resources Office)

OSAN YOUTH SPORTS
COACH/VOLUNTEER APPLICATION

sports youth programs

Personal Information

Last Name, First Name, MI:		**DEROS:**
Address:	City:	Zip
Phone:	Alternate Phone:	
Email:	Alternate Email:	
Date of Birth:	☐ Active Duty ☐ Civilian	Rank:

Youth in program? ☐ YES or ☐ NO

If so, name(s):

I would like to: ☐ Coach ☐ Volunteer ☐ Both

Coaching

☐ Head Coach ☐ Assistant Coach

Sports Coaching For:

☐ Soccer ☐ Softball ☐ Boys Basketball ☐ Girls Basketball

☐ Cheerleading ☐ Flag Football ☐ Baseball ☐ Volleyball

Preferred Age Group:

☐ Pee-Wee (5-6) ☐ Bantam (7-8) ☐ Minor (9-10) ☐ Majors (11-12) ☐ Juniors (13-15)

Previous Coaching Experiences:

Volunteering

STEM Club Kids in the Kitchen Gym/Fitness

Other(s):

Previous Volunteer Experiences:

References

(Must provide TWO references. They can be personal, professional, or educational.)

First:		Last:
Phone:	Alternate Phone:	Email:
First:		Last:
Phone:	Alternate Phone:	Email:

Background Information

Have you ever been arrested for or charged with a crime involving a child? ☐ Yes ☐ No

If yes, please provide a description of the disposition of the arrest or charge(s):

Have you ever been arrested for or charged with a crime involving drugs or alcohol? ☐ Yes ☐ No

If yes, please provide a description of the disposition of the arrest or charge(s):

Consent and Release

By signing this application, I, hereby, authorize and consent the Osan Youth Sports Programs to obtain information regarding my background and history. This may include but is not limited to: my employment records and references; personal references; criminal background records and information; criminal background check and fingerprinting; driver's license check; volunteering experiences; and other training experiences.

I agree to conform to adhere to AFI 34-144 regulations while volunteering for the program, and to refrain from the use of alcohol, tobacco, and illegal substances while in the program.

I will remember that coaching is a privilege and not a right. I can be relieved of my coaching duties at any time if I fail to live up to the standards set forth for all youth sports coaches at Osan Air Base, Republic of Korea.

I understand I am required to have a completed Installation Records check containing a records check of all installations on which I've lived or worked for two years before the date of this application.

I have read and understand the Osan Youth Guidance Policy.

Signature:	Date:

Office Use Only

☐ Copy of CPR Certification ☐ Copy of First Aid Certification

VOLUNTEER AGREEMENT FOR

☐	APPROPRIATED FUND ACTIVITIES	✘	NONAPPROPRIATED FUND INSTRUMENTALITIES

PRIVACY ACT STATEMENT

AUTHORITY: Section 1588 of Title 10, U.S. Code, and E.O. 9397.

PRINCIPAL PURPOSE(S): To document voluntary services provided by an individual, including the hours of service performed, and to obtain agreement from the volunteer on the conditions for accepting the performance of voluntary service.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however failure to complete the form may result in an inability to accept voluntary services or an inability to document the type of voluntary services and hours performed.

PART I - GENERAL INFORMATION

1. TYPED NAME OF VOLUNTEER *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYYMMDD)*

4. INSTALLATION	5. ORGANIZATION/UNIT WHERE SERVICE OCCURS
OSAN AB, SOUTH KOREA	51 FSS/FSY

6. PROGRAM WHERE SERVICE OCCURS	7. ANTICIPATED DAYS OF WEEK	8. ANTICIPATED HOURS
CHILD & YOUTH PROGRAMS	TBD	TBD

9. DESCRIPTION OF VOLUNTEER SERVICES

Child & Youth program activities, sports, field trips, etc.

PART II - VOLUNTEER IN APPROPRIATED FUND ACTIVITIES

10. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services, tort claims, the Privacy Act, criminal conflicts of interest, and defense of certain suits arising out of legal malpractice. I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services I will be providing.

a. SIGNATURE OF VOLUNTEER	b. DATE SIGNED *(YYYYMMDD)*
N/A	N/A

11.a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*
N/A	N/A	N/A

PART III - VOLUNTEER IN NONAPPROPRIATED FUND INSTRUMENTALITIES

12. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services and liability for tort claims as specified in 10 U.S.C. Section 1588(d)(2). I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers, and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services that I am offering.

a. SIGNATURE OF VOLUNTEER	b. DATE SIGNED *(YYYYMMDD)*

13.a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART IV - TO BE COMPLETED AT END OF VOLUNTEER'S SERVICE BY VOLUNTEER SUPERVISOR

14. AMOUNT OF VOLUNTEER TIME DONATED				15. SIGNATURE	16. TERMINATION DATE *(YYYYMMDD)*
a. YEARS *(2,087 hours = 1 year)*	b. WEEKS	c. DAYS	d. HOURS		

17.a. TYPED NAME OF SUPERVISOR *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

ACKNOWLEDGMENT OF RIGHTS
AND
CONSENT TO RELEASE RECORDS

AUTHORITY: 42 U.S.C. 13041 AND 10 U.S.C. 8013

PRINCIPAL PURPOSE: To comply with Public Law 101-647, Section 231, and DoDI 1402.5, Criminal History Background Checks on Individuals in Child Care Services.

DISCLOSURE: Mandatory. In the case of an applicant for employment in a position involved with children under the age of 18, refusal to sign this form shall result in the employer's refusal to consider the application for employment. In the case of an incumbent of a position involved with children under the age of 18, refusal to sign this form shall result in removal from such position.

EMPLOYEE ACKNOWLEDGMENT:

1. I have been advised and understand that the United States Air Force, as a Federal employer, has an obligation to require a record check as a condition of my employment in a position involved with children under the age of 18. I have been further advised that I have a right to obtain a copy of any criminal history report made available to such employer or potential employer and to challenge the accuracy and completeness of any information included in such report.

2. I understand that the record check will include the following:

   a. A State Criminal History Repository Check in the state where I currently reside and in states where I have formerly resided;

   b. An Installation Records Check at all installations I have identified as residences during the preceding two years. This records check will include, as a minimum, inquiries of the Security Police, Medical Treatment Facility, Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, the Family Housing Office, and the Family Advocacy Office. Sponsor's SSN is needed for medical records review.

   c. A National Agency Check with Inquires, including a Federal Bureau of Investigation fingerprint check.

   d. A name check of the Dru Sjodin National Sex Offenders Registry.

   e. A DCII (Defense Central Index of Investigations) check with the Office of Special Investigations (OSI).

3. I hereby authorize any Federal, state, or local agency or office to release any record relating to me which is necessary to complete the record checks described above.

TYPED OR PRINTED NAME: ____________________

SSN: ____________________

SIGNATURE: ____________________

DATE: ____________________

DEPARTMENT OF THE AIR FORCE
51ST FORCE SUPPORT SQUADRON (PACAF)
UNIT 2065
APO AP 96278-2060

MEMORANDUM FOR SECURITY FORCES/FAMILY ADVOCACY/ALCOHOL AND DRUG PREVENTION AND TREATMENT/AFOSI

FROM: 51 FSS/FSCN

SUBJECT: Installation Records Check

1. The individual listed below has applied for a volunteer, contract, family child care or paid position within Child and Youth Programs. In accordance with DoDI 1402.05 and AFI 34-144, the position is subject to a records review. An Installation Record Check (IRC) is required for individuals with DoD affiliation who work with children under 18 years of age. The IRC must include a records check with **Security Forces (SFMIS)/Alcohol and Drug Prevention and Treatment (ADAPT)/**
Family Advocacy (Central Registry)/AFOSI (DCII & I2MS).

APPLICANT'S NAME: ______________________________ APPLICANT'S SSN: _________________________

ADDRESS: ____ PHONE NUMBER: ____________________________

____

PLACE OF BIRTH: _________________________________ DATE OF BIRTH: _____________________________

SPONSOR'S NAME: ________________________________ SPONSOR'S SSN: ___________________________

SPONSOR'S SIGNATURE: ______________________________________ DATE: __________________________

2. Do your records indicate any reason why this individual should not perform duties involving children? If so, please provide details in the remarks section.

3. Because applicants must have a favorably completed IRC before they can be appointed to a position, the IRC must be processed as quickly as possible. Any delays in this process could have an adverse affect on Child and Youth Programs. If you have any questions, please do not hesitate to contact our office at 315-784-1398 or 51fss.hro@us.af.mil. Thank you for your assistance.

LILY REICHARDT, NFII, NAF
Human Resources Assistant

Attachment

This memorandum contains FOR OFFICIAL USE ONLY (FOUO) information which must be protected under the Freedom of Information Act (5 U.S.C. 552) and/or the Privacy Act of 1974 (5 U.S.C. 552a). Unauthorized disclosure or misuse of this PERSONAL INFORMATION may result in disciplinary action, criminal and/or civil penalties. Further distribution is prohibited without the approval of the author of this message unless the recipient has a need to know in the performance of official duties. If you have received this message in error, please notify the sender and delete all copies of this message.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*

5. TYPE OF TREATMENT *(X one)*
- [ ] OUTPATIENT
- [ ] INPATIENT
- [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Osan Mental Health Clinic / ADAPT / Family Advocacy Program TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
51 FSS/FSCN, NAF Human Resources Office	**Unit 2065, APO, AP 96278-2065**
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
- [ ] PERSONAL USE
- [ ] INSURANCE
- [ ] CONTINUED MEDICAL CARE
- [ ] RETIREMENT/SEPARATION
- [ ] SCHOOL
- [ ] LEGAL
- [X] OTHER *(Specify)*

8. INFORMATION TO BE RELEASED

Any information that would affect my mental and emotional stability working with children; ADAPT/Mental Health/Life Skills/Family Advocacy.

9. AUTHORIZATION START DATE *(YYYYMMDD)*

10. AUTHORIZATION EXPIRATION
- [ ] DATE *(YYYYMMDD)*
- [X] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

SPONSOR NAME:
SPONSOR RANK:
FMP/SPONSOR SSN:
BRANCH OF SERVICE:
PHONE NUMBER:

REQUEST FOR INSTALLATION RECORDS CHECK (IRC)

OMB 701-

PRIVACY ACT STATEMENT

AUTHORITY: Executive Order 10450 and/or Section 231 of the Crime Control Act of 1990 (42 U.S.C. 13041); DoD Instruction 1402.05, Criminal History Background Checks on Individuals in Child Care Services

PRINCIPAL PURPOSE(S): To require each employee, contractor, family child care provider (FCC) and their family members ages 12 and above, and specified volunteer that have regular contact with children under 18 years of age undergo an IRC. This checks covers a five year period, with the exception of FCC providers and their family members which is conducted annually, at the end of which a new IRC must be initiated. When completed, records are covered by SORN: http://dpclo.defense.gov/privacy/SORNs/component/airforce/F034_AF_SVA-C.html

ROUTINE USES: This form is used to request installation records check of Air Force child and youth workers. This form will be initiated by personnel or security personnel.

DISCLOSURE: Voluntary; however, failure to furnish all requested information including SSN may result in an unfavorable adjudication decision and may affect suitability of working with or around children.

I. APPLICANT INFORMATION

1. NAME Last, First, Middle (Maiden, Other Alias)

2. ORGANIZATION/OFFICE SYMBOL
51 FSS / FSYY

3. GRADE

4. SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___

5. Citizenship: ☐ US ☐ Immigrant Alien ☐ Non-US National

6. DATE OF BIRTH

7. PLACE OF BIRTH (City, State and Country)

8. Status: Active Duty
___ Family Member Civilian

9. HOME ADDRESS

10. DATE

11. APPLICANT'S SIGNATURE

II. MILITARY SPONSOR INFORMATION *(if applicable)*

12. NAME Last, First, Middle

13. SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___

14. DATE

15. SPONSOR'S SIGNATURE

III. PERSONNEL OR SECURITY CONTACT INFORMATION

16. ORGANIZATION/OFFICE SYMBOL
51 FSS / FSCN

17. DATE

18. PRINTED NAME AND GRADE OF REQUESTER

19. SIGNATURE

20. PHONE NUMBER
784-1398

IV. FOR AGENCY USE ONLY

☐ SECURITY FORCES ***(SFMIS)***

☐ MENTAL HEALTH

☐ FAMILY ADVOCACY ***(Central Registry)***

☐ DRUG & ALCOHOL

☐ GOVERNMENT HOUSING (***AF Only -- AF Form 4422)***

21. Applicant's name reflected in database? ☐ YES ☐ NO

22. Derogatory information on file that would preclude working with children? ☐ YES ☐ NO

23. Derogatory Information Remarks/Disposition *(If more space is needed use reverse and show item number being used)*

I CERTIFY a records check required by DoDI 1402.05 and AFI 34-144 has been completed and no information exists, unless shown above, that precludes working with children.

24. PRINTED NAME and ORGANIZATION/OFFICE SYMBOL

25. SIGNATURE

26. TITLE

27. PHONE NUMBER

28. DATE

Fingerprints

Please contact the NAF HR office to schedule an appointment:

51 FSS/FSCN
NAF HUMAN RESOURCES
Bldg 936, 1st Floor
DSN: 784-1398
Email: 51fss.fsmh@us.af.mil

NAME: ______________________________________

FACILITY: **FSYY**

POSITION: **VOLUNTEER / COACH**

OFFICE USE ONLY:

I certify that the above named individual has completed their fingerprints.

Signature: ______________________________

Date: _________________________