



MEMORANDUM FOR CAMP ZAMA VOLUNTEER COACH



SUBJECT: Volunteer Application Process

Thank you for volunteering to coach the youth/teens in our community. This program depends on people like you stepping up and giving your time. Below is the volunteer process to coach for YSF;

1. Please go to our website, Central Enrollment Office or our office for forms to sign.
2. Please fill out all forms and make sure to sign where required.
3. Return all documents to our office (Youth Center, BLDG #314).
4. The Coach's checklist must be completed before you are allowed to be a coach.

If you have any questions, please feel free to contact us at the Youth Sports and Fitness Office 263-5437

YOUTH SPORTS AND FITNESS DIRECTOR

ROBERT SANTANA

Attachments;

- (1) Coaching Application
- (2) Request for Background Information and Investigation
- (3) Statement Authorizing Release of Privacy Act Information
- (4) CDS Background Clearance Request, DA Form 5220-R
- (5) ADAPCP Client's Consent Statement for Release of Treatment Information, DA Form 5018-R

IMPC-JA-MWC

SUBJECT: Request Information and Investigation

SEE DISTRIBUTION

1. Request that background checks be completed for the following person selected for a volunteer position within ten days. A statement authorizing release of information is on the reverse. The individual named below has applied for authorization to provide volunteer work at the U.S. Army Garrison CYS Youth Sports program as specified in AR 608-10 and AR 215-1.

Applicant's Name (Last, First, Middle, Maiden) SSN

Sponsor's Name (Last, First, Middle, Maiden) SSN

Date & Place of Birth of Applicant

Unit Address of Sponsor

2. Result of File Checks

Files contain no adverse information.

Files reveal adverse information

Remarks:

3. Applicant cannot enter onto volunteer status without completed checks. Request check be expedited and returned within the stated time frame to:

USAG-J, Director MWR
Unit 45006
Attn: IMPC-JA-MWC-YS
APO AP 96343-5006

4. I have read and understand the privacy statement on the next page.

Applicant Signature/Date

YS Director/Date

Distribution:

- (1) Provost Marshall;
- (2) Criminal Investigation;
- (3) Clinical Director;
- (4) Army Drug & Alcohol Prevent and Control Program;
- (5) FACMT

**STATEMENT AUTHORIZING RELEASE OF PRIVACY ACT INFORMATION
(Privacy Act of 1974)**

AUTHORITY: 10 U.S.C., SECTION 3012 (g)

PRINCIPAL PURPOSE:

This information will be used to process applications and will remain confidential, will not be released to other individuals or agencies without a need to know, and will only be used to monitor the Youth Service programs.

ROUTINE USE:

In accordance with AR 608-10, Child & Youth Services require information from the following agencies for the purpose of completing the screening required to obtain a Youth Services Coach or Volunteer certificate. These agencies include:

Provost Marshall
Army Drug and Alcohol Prevention and Control Program
Clinical Director
Family Advocacy Case Management Team (FACMT)
Criminal Investigation Division (CID)

MANDATORY OR VOLUNTARY DISCLOSURE

Disclosure of information on this waiver or within the application is voluntary; however, failure to provide information on the application or failure to allow relinquishment of information will cause the application to be rejected.

Applicant Signature/Date

YS Director/Date

**CHILD DEVELOPMENT SERVICES (CDS) FAMILY CHILD CARE (FCC)
PROVIDER BACKGROUND CLEARANCE REQUEST**

For use of this form, see AR 608-10; the proponent agency is DCSPER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013

PRINCIPAL PURPOSE: To provide background information regarding prospective FCC Providers to CDS personnel for use in the certification process.

ROUTINE USES: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, certification of the candidate may be denied.

NAME OF APPLICANT (<i>Last, first, MI</i>)	DATE
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Applicant has applied for certification as a Family Child Care (FCC) Home Provider within the _____ quarters-based Family Child Care Home System. This office must pursue all means to verify the competency of _____ to provide for the physical, social, emotional and intellectual needs of young children in a caregiving situation within his/her own home.

CHARACTER REFERENCE INFORMATION

TO YOUR KNOWLEDGE, DOES THIS INDIVIDUAL	<i>Check One</i>		
	YES	NO	N/A
1. RELATE TO CHILDREN AND ADULTS IN A SENSITIVE AND POSITIVE MANNER			
2. HAVE THE STAMINA, PATIENCE AND CAPABILITY TO CARE FOR CHILDREN FOR SUSTAINED TIME PERIODS			
3. SHOW EVIDENCE OF REPUTABLE CHARACTER			
4. ACT RESPONSIBLY IN CRISIS SITUATIONS			
5. MAINTAIN A SAFE, AND SANITARY HOME			
6. SPEAK, READ AND WRITE ENGLISH TO THE EXTENT HE/SHE CAN EXECUTE HEALTH AND SAFETY DIRECTIONS AND CAN PLAN PROGRAM ACTIVITIES FOR CHILDREN			
7. SHOW ANY EVIDENCE OF MENTAL HEALTH PROBLEMS WHICH COULD ADVERSELY AFFECT THE HEALTH OR SAFETY OF CHILDREN IN CARE			
8. HAVE ANY ANIMAL(S) WHICH MIGHT POSE A THREAT TO CHILDREN'S WELL BEING			
9. TO YOUR KNOWLEDGE HAS THERE BEEN ANY CONVICTION OF, ADMISSION TO, OR SUBSTANTIVE EVIDENCE OF AN ACT OF CHILD ABUSE (<i>i.e. battering, molesting, etc.</i>) OR NEGLIGENCE; USE OF ILLEGAL DRUGS OR ALCOHOL ABUSE BY THIS INDIVIDUAL OR ANY RESIDENT OF THE FCC HOME			
10. HOLD ANOTHER JOB, EITHER FULL TIME OR PART TIME, DURING THE HOURS CHILDREN WOULD BE IN CARE			

REMARKS: EXPLAIN ANY (NO) ANSWERS TO ITEMS 1 - 6 AND (YES) ANSWERS TO ITEMS 7 - 10. ADDITIONAL INFORMATION RELEVANT FOR THE PURPOSES OF THIS BACKGROUND CLEARANCE REQUEST MAY BE PROVIDED ON THE REVERSE SIDE. INFORMATION ABOUT OTHER INDIVIDUALS RESIDING IN THE HOME MAY BE ADDRESSED IN THIS SPACE.

TITLE	ADDRESS	SIGNATURE (<i>Person submitting information</i>)
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SUBMIT THIS FORM TO ADDRESS LISTED BELOW

ADDRESS _____

ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCSPER.

SECTION A - CONSENT

I, _____, this _____ day of _____, 19____,
(client's full name)
do hereby voluntarily consent to the release of the following information by US Army Garrison, Japan
(name of installation ADAPCP)
pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with
alcohol or other drug abuse education, training, treatment, rehabilitatiton, or research to Child & Youth Services
Youth Sports Director for the purpose of volunteer coach background check

_____ namely,
any information on file with the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), including the
(extent or nature of information to be disclosed)
Adolescent Substance Abuse Service (ASACS)

SECTION B - EXPIRATION/REVOICATION
(Check applicable paragraph)

1. I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3), AR 600-85)
2. I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to _____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ADAPCP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS <i>(Type or print)</i>	SIGNATURE	DATE
Robert Santana, YS Sports Director		

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.

In my judgment, the release of an evaluation of the present or past status of _____
(client's name)
in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE <i>(Type or print)</i>	DATE
SIGNATURE	