ausm
autism society of minnesota

2380 Wycliff Street, Suite 102 • St. Paul, MN 55114
Telephone: 651-647-1083 • *Fax:* 651-642-1230 • *Website:* www.ausm.org • *Email:* camp@ausm.org

Application for Seasonal AuSM Camp Employment - 2018

Last Name	First Name	Middle Name	
Street address		Date of Birth (**Required** for background check)	Gender (please check one) ☐M ☐F
City	State Zip Code + Suffix	County of Residence	Social Security Number
Email Address	Phone (Cell)	Phone (Home)	Phone (Work)
MN Drivers License # or State ID #	List all other names by which you have been known:	List all other Counties in which you have lived during the past 5 years:	
****Indicate alternate address to where you would like your check sent, if different than above:**			

Indicate all camps, positions and weeks for which you have interest in working:

Camp Hand in Hand	Camp Discovery	Wahode Day Camp
Session	**Session**	**Sessio**
1 **June 22 – 29 (males 19-24, females 19-25)** ALL Staff arrive after 6PM on 6/22/18 Training begins at 9AM 6/23/18	**1** **June 16 – June 22 (co-ed 10-17)** Arrive on 6/16/18 for training beginning at 3pm (tentative)	**1** **July 9 - July 13, 2018** *(Camp Butwin, Eagan)
2 **July 27 – August 3 (boys 15-19)** ALL Staff arrive after 6PM on 7/27/18 Training begins at 9AM 7/28/18	**2** **June 23 – June 29 (co-ed 18-25)** Arrive on 6/23/18 for training beginning at 3pm (tentative)	**2** **July 23 - July 27, 2018** *(Camp Butwin, Eagan)
3 **August 3 – 10 (males 24+, females 26+)** ALL Staff arrive after 6PM on 8/3/18 Training begins at 9AM 8/4/18	• **If riding bus to camp, contact the AuSM office. Arrive with campers on the day <u>after</u> first date listed above** • **Bus loads at AuSM offices: 9:30 AM on June 17 and 24 (tentative times)**	
4 **August 10 – 17 (boys 9-14, girls 9-18)** ALL Staff arrive after 6PM on 8/10/18 Training begins at 9AM 8/11/18	**Headwaters Autism Adventure** **July 27-Aug. 3 (co-ed 13-17)** training TBD campers arrive July 27	**Wahode Day Camp training** **Wed. June 13th, 7-9 PM** **at AuSM office in St. Paul**

Available Positions	CHECK WEEK(S) 1	2	3	4	Available Positions	CHECK WEEK(S) 1	2	HAA	Available Positions	CHECK WEEK(S) 1	2	
☐ **Program Staff** (Must have several years of experience with Autism/ASD)	☐	☐	☐	☐	☐ **Cabin Support Staff** (Must have several years of experience working with those with Autism/ASD)	☐	☐	☐	☐ **Program Staff** (Must have several years of experience with Autism/ASD)	☐	☐	
☐ **Counselor**	☐	☐	☐	☐	☐ **Mentor** (This is an individual with ASD)	☐	☐		☐ **Counselor**	☐	☐	
☐ **Volunteer**	☐	☐	☐	☐	☐ **Other:**	☐	☐		☐ **Volunteer**	☐	☐	
☐ **Nurse (RN)**	☐	☐	☐	☐					☐ **Other:**	☐	☐	

Emergency Information

Emergency Contact Person	Address	Relationship to you
Phone (H)	Phone (W)	Phone (C)
Health Care Provider	Physician's Phone	Insurance #
Please state any health information that might affect your job performance at camp		

Education History ***ALL Applicants must fill out this page and sign at the bottom***

School name	Location (city, state)	Major course or subject	Dates attended From	To	Graduated Yes	No	Degree
High school					☐	☐	
College (list all attended)					☐	☐	
					☐	☐	
					☐	☐	

Employment Record **All Applicants**

List present or most recent employer. You may attach a resume, but complete this application as well.

Last or present company	Type of business	Type or classification of job
Street address	Phone number	Brief description of job duties
City	State ZIP code	
Supervisor's name	Phone number	
Base salary	Dates worked From To	Reason for leaving

May we contact your present employer? ☐ **Yes** ☐ **No**

Professional / Work References

List complete information for one past supervisor and one person (who is not related to you) who have knowledge of your qualifications for the position for which you are applying. ***A reference form will be sent to individuals listed below.***

Name	Title/relationship	Address (EMAIL and complete address)	Phone no. (include area code)	Occupation

Other acquired skills and/or experience, particularly related to working with children, children with autism and/or camping:

What t-shirts size will you need? ☐ S ☐ M ☐ L ☐ XL ☐ XXL

***Where did you hear about AuSM camps? (Please be specific)

***Some camp families ask for contact information for camp staff that are interested in working as a PCA for their child, after the camp season. Would you be interested? If yes, can we share your contact information (name, phone, email)? ☐ Yes ☐ No ***

An Equal Opportunity Employer We are an equal opportunity employer, and we do not and will not discriminate on the basis of race, religion, national origin, sex, age, handicap, marital status, or status as a disabled veteran. Information provided on this application will not be used for any discriminatory purpose. Your complete application form will be valid for the duration of the application calendar year. You may submit a new application at any time and are responsible to notify AuSM of any changes of address or other contact information.

Confidentiality All information provided herein is considered confidential and will not be shared with any third party without consent.

Provide All Information Requested I understand that all information provided herein will be subject to a Background Check, check of references and employer, and that my employment may be contingent upon receipt of an alien registration number, verification of birth, and any other pertinent information bearing upon my employment.

I hereby certify that the answers and other information on this application are true and correct. I understand that my continued employment depends upon the will of the company or myself. **(You MUST SIGN and date below to be considered for employment)**

Name (Please print) _____

***SIGNATURE** _____ Application Date _____

Must be signed

*By typing your name on the signature line above, you acknowledge it to be binding in substitution for your handwritten signature and that it indicates your approval of the information contained in this document.

CHILD PROTECTION BACKGROUND CHECK ACT FORM

Autism Society of MN
2380 Wycliff St. Suite 102
St. Paul, MN 55114
651-647-1083 ext 16

Because the position for which you are applying will require you to provide care, treatment, education, training, instruction, or recreation to children, Autism Society of MN will request the Bureau of Criminal Apprehension (BCA) to perform a criminal background check on you under Minnesota Statutes Chapter 299C.62.

Have you ever been convicted of any of the following crimes? (If yes, please attach a description of the crime and the particulars of the conviction.) ☐ Yes ☐ No

Background check crimes under Minnesota Statutes Chapter 299C.62

-- Murder
-- Criminal Sexual Conduct
-- Any Assault Crime Against a Minor
-- Felony Level Assault
-- Manslaughter
-- Prostitution-Related Crime
-- Kidnapping
-- Arson
-- Any of the following Child Abuse Crimes committed against Minor victim, constituting a violation of Minnesota Statutes Sections:

609.185,(5) Murder in the 1st Degree
609.221 Assault in the 1st Degree
609.222 Assault in the 2nd Degree
609.223 Assault in the 3rd Degree
609.224 Assault in the 5th Degree
609.2242 Domestic Assault
609.322 Solicitation, Inducement and Promotion of Prostitution
609.324 Other prohibited acts of Prostitution
609.342 Criminal Sexual Conduct in the 1st Degree
609.343Criminal Sexual Conduct in the 2nd Degree
609.344 Criminal Sexual Conduct in the 3rd Degree
609.345 Criminal Sexual Conduct in the 4th Degree
609.352 Solicitation of Children to Engage in Sexual Conduct
609.377 Malicious Punishment of a Child
609.378 Neglect or Endangerment of a Child
152.021, subd.1,(4) Controlled Substance Crime in 1st Degree
152.022, subd.1,(5) or (6) Controlled Substance Crime in 2nd Degree
152.023, subd.1,(3) or (4) Controlled Substance Crime in 3rd Degree
152.023, subd.2,(4) or (6) Controlled Substance Crime in 3rd Degree
152.024, subd.1,(2), (3) or (4) Controlled Substance Crime in 4th Degree

As the subject of a Child Protection background check, your rights include:

- to be informed that The Autism Society of MN will request this check for becoming or continuing as an employee or volunteer, and to determine whether you have been convicted of any of the above specified crimes, and
- to be informed of the BCA's response and obtain a copy of the report from The Autism Society of MN,
- to obtain from the BCA any record that forms the basis for the report, and
- to challenge the accuracy and completeness of any information contained in the report (procedures set forth in MN Statutes §13.04 and Title 28, CFR, Section 16.34), and
- to be informed whether The Autism Society of MN has denied your application because of the BCA's response and not to be required directly or indirectly to pay the cost of the background check.

Last Name of Applicant (please print): _____

First Name (please print): _____
Middle (full) (please print): _____
Maiden, Alias or Former (please print): _____

Date of Birth: ____ **Sex** (M or F): __ **Social Security Number**: _____
Month/Day/Year (Optional)

***Signature of Applicant**: _____ **Date**: ___

This release is valid for one year from the date of my signature.

*By typing your name on the signature lines in this document, you acknowledge it to be binding in substitution for your handwritten signature and that it indicates your approval of the information contained in this document.

1. Records obtained under the Minnesota Statutes Chapter 299C.62 may be used solely for the purpose requested and cannot be disseminated outside the receiving departments, related agencies, or other authorized entities.
2. Your fingerprints may be used to check the criminal history records of the FBI.

Informed Consent
Release of Predatory Offender
Registration Data

Please print **legibly**-use **complete** name, including **middle name**

First Name _____ Middle Name _____ Last Name _____
Maiden or Former Last Name (s) _____
Date of Birth _____ Social Security number _____
Driver's License Number _____ Issuing State ____

Current Address _____
City, State, Zip Code _____

Because the position for which you are applying will require you to provide care, treatment, education, training, instruction, or recreation to children, The Autism Society of MN will request the Bureau of Criminal Apprehension (BCA) to perform a POR check on you in conjunction with a criminal history check pursuant to Minnesota Statutes §299C.62

I hereby authorize and grant my informed consent to the Minnesota Bureau of Criminal Apprehension to release to The Autism Society of MN any information contained about me in the Minnesota Predatory Offender Registry, including, but not limited to, information related to offenses which may have occurred when I was a juvenile.

I hereby release the Minnesota Bureau of Criminal Apprehension and The Autism Society of MN from any and all actions and causes of action, of any kind and nature whatsoever, past, present and future, arising out of the release of information obtained with this consent.

This authorization shall be valid for a period of twelve (12) months from the date of signature.

*Signature _____ Date _____

*By typing your name on the signature lines in this document, you acknowledge it to be binding in substitution for your handwritten signature and that it indicates your approval of the information contained in this document.