MDUSD VOLUNTEER REQUIREMENTS

We are so thankful that you have considered becoming a volunteer! Valhalla thrives on the help from all volunteers. Please see below instructions on how to complete the attached forms for instructions on getting volunteer clearance. Each person that would like to volunteer MUST complete all requirements through MDUSD.

REQUIRED FORMS FOR VOLUNTEERING:

1. Volunteer Request Form
2. Livescan Application
3. TB Clearance

1. VOLUNTEER REQUEST FORM

Complete the attached volunteer request form.

2. LIVESCAN CLEARANCE:

Complete the MDUSD Livescan application. Please bring your Livescan Form and VALID PHOTO I.D. to the Livescan location for fingerprinting.

Livescan fingerprinting can be completed TODAY at Valhalla All in One! ☺

2. TB CLEARANCE:

Contact your physician for a **current** tuberculosis (TB) clearance, required by law. If you do not have a physician, you can contact Concentra. The Tuberculosis Risk Assessment form, a form from the California Department of Public Health, which may be an option in lieu of a skin test (your physician will determine). Please allow for the 48 hour reading requirement if a skin test is necessary. **Proof of TB clearance cannot be older than 60 days from your fingerprint appointment**. Please note, TB clearance must be renewed every **four** years.

PLEASE RETURN ALL COMPLETED FORMS VIA:

EMAIL: personnelfrontdesk@mdusd.org

OR

FAX: Fax to (925) 676-4092.

OR

US Mail: Mail to MDUSD district office located
1936 Carlotta Drive, Concord, CA 94519.

OR

Hand Deliver: You can also hand deliver/drop off completed forms to the MDUSD district office. 936 Carlotta Drive, Concord, CA 94519.

You will not be added to our master list of school volunteers until ALL required documents have been received at the district office, and your fingerprints have been cleared by the Department of Justice, which can take 1-30 days.

If you have any questions or concerns, please call (925) 682-8000 ext. 4153 or email personnelfrontdesk@mdusd.org.

MT. DIABLO UNIFIED SCHOOL DISTRICT
JAMES W. DENT EDUCATION CENTER
1936 Carlotta Drive
Concord, California 94519-1397
www.mdusd.org
(925) 682-8000
FAX (925) 676-4092

HUMAN RESOURCES

VOLUNTEER REQUEST FORM

Date: _____

Thank you for taking the time to become a volunteer for Mt. Diablo Unified School District.

Fingerprinting: Administrative Regulation (AR) 1240, approved by the Board of Education on August 26, 2003, states that all volunteers be fingerprinted for a background check with the California Department of Justice (DOJ) prior to volunteering. **Fingerprints do not expire**, and are valid throughout the school district. Fingerprinting is done at the district office by appointment only. Please schedule your appointment online at: **mdusd.org; then go the Human Resources tab, then click on Volunteer Instructions.**

Valid I.D.: You will need to bring permanent, valid identification with you to your fingerprint appointment. Expired or temporary forms of I.D. **cannot** be accepted. Please visit our website for a list of valid forms of I.D.

Tuberculosis (TB) Clearance: You must also provide evidence of medical clearance from tuberculosis, obtained within 60 days of being fingerprinted. You can bring your TB clearance up to 60 days after your fingerprint appointment. **You will not be cleared to volunteer until our office receives this documentation.**

Fees: There is a **$32.00 fee for fingerprinting.** (The fee is $49.00 if you have lived in California for less than one year.) You can pay with cash (exact change only please), or money order or cashier's check made payable to Mt. Diablo Unified School District. **No personal checks, credit or debit cards will be accepted.**

Volunteer Name: _____

Student Name(s): _____

School(s): _____

Please check one:
□ Parent/Guardian/Family Member □ Community Member □ Student □Other: _____

Disclaimer: Mt. Diablo Unified School District is not responsible for, nor has any authority over DOJ response time. Once fingerprints are submitted, it may take up to 30 days or longer for clearance to occur.

TO BE COMPLETED BY DISTRICT PERSONNEL:

Once you are cleared to volunteer, this form will be mailed to you for your records.

TB clearance remains valid for **4 years,** and it is your responsibility to update it when expired.

TB Expiration Date: _____

Volunteer Clearance Date
Invalid without District Stamp

☑ Volunteer

MT. DIABLO UNIFIED SCHOOL DISTRICT
JAMES W. DENT EDUCATION CENTER
1936 Carlotta Drive
Concord, California 94519-1397
www.mdusd.org
(925) 682-8000

REQUEST FOR LIVESCAN SERVICE – APPLICATION SUBMISSION

APPLICATION INFORMATION

Name _____
Last First Middle

Alias/Maiden Name _____
Last First Middle

Date of Birth _____ ☐ Male or ☐ Female
Month/Date/Year

Height _____ Weight _____ Eye Color _____ Hair Color _____

Place of Birth:
If born within the United States: City: _____ State: _____

If born outside the United States:

City: _____ State: _____ Country: _____

Country of Citizenship: _____ Documented: ☐ Yes ☐ No

S.S. # ☐☐☐-☐☐-☐☐☐☐ CA Driver's Lic. # _____ EXP:___

Street Address: _____

City: _____ State: _____ Zip Code: _____

Resident of California (Number of Years) _____ Telephone: ( ) _____

IF LESS THAN 1 YEAR – BOTH DOJ AND FBI ARE REQUIRED

MDUSD Job Title: **VOLUNTEER** School Site(s):

District Personnel Use Only: ORI: A1160

Level of Service Requested: ☑ D.O.J. ☐ F.B.I.

Type of Application: ☐ Employment ☐ License/Permit ☐ Certification ☑ Volunteer

Email Code: ☐ 03205 Certificated ☐ 03226 Classified ☑ 03226 Volunteer

_____
Operator Name

_____
Service Location Name

_____
Transmittal Date

_____
RE-Submittal Date

_____
Person Requesting Clearance

ATI #: _____

R2 ATI # _____

_____
Date of D.O.J. Response

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new risk factors since the last negative test.**
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:**
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Disease or Infection (Check appropriate box below)

☐ **Yes**
- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked

☐ **One or more sign(s) or symptom(s) of TB disease**
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

5/06/20