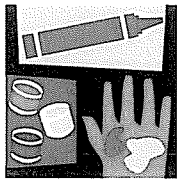


# VOLUNTEERS

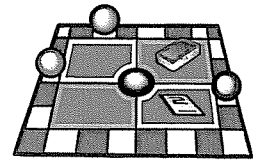
Thank you for volunteering your time at the Tammy Lynn Center for Developmental Disabilities. We are pleased to have you here and hope you enjoy your experience with us.

Below is a list of activities for you to participate in with residents and students:



- Reading
- Arts & Crafts
- Hand massages with lotion
- Music groups

- Paint fingernails
- Play board games
- Painting
- Drawing



Feel free to ask staff for other suggestions that different individuals may enjoy!

Also, as a reminder:

- Make sure to fill out your time card each and every visit and turn in at the end of the month.
- Properly display your volunteer name badge while on Campus.
- TLC is a drug and tobacco free campus. Smoking is not allowed at anytime on campus.
- Please refrain from wearing any scented perfumes, colognes, lotions, or body sprays while volunteering at the Center.
- Ensure proper shoes are on at all times.

**In Case of a Volunteer Emergency:**

Eshe Hamme, Outreach & Events Coordinator  
919-755-2661 – Monday – Friday 8am – 5pm



# HOW YOU CAN HELP

**V**olunteers are vital to the success of the Tammy Lynn Center for Developmental Disabilities. Your volunteer experience should be rewarding, fun and equally beneficial to the students and residents and to the Center.

*Below are just a few ways to get involved with Tammy Lynn...*

- ♥ Serve as a direct care volunteer with the residents or students.
- ♥ Serve on a special event committee: *A Toast to the Triangle™*, Ride for Tammy Lynn or Tammy Lynn Golf Classic.
- ♥ Host a social event to introduce Tammy Lynn to your friends and colleagues.
- ♥ Bring your co-workers to the Center for a Day of Service.
- ♥ Speak about the Center at a business breakfast or lunch.
- ♥ Offer your professional expertise as an in-kind service.
- ♥ Become an advocate for people with special needs.



We encourage all potential volunteers to take a tour of the Center to become better acquainted with our campus and our mission. An application process, which includes a negative TB test, must be completed by those individuals wishing to spend time with our students and residents. In this way, we ensure that the best people become Tammy Lynn volunteers!

For more information, please call 832-3909 or email at [info@tammylynncenter.org](mailto:info@tammylynncenter.org).

## TAMMY LYNN CENTER VOLUNTEER INTAKE FORM

This form serves as initial contact with the Development Office of Tammy Lynn Center for Developmental Disabilities. Submission of this form by no means guarantees admission into the volunteer program. Subsequent paperwork and testing may be applicable.

Name: \_\_\_\_\_

Volunteer Interests/Talents:

\_\_\_\_\_  
\_\_\_\_\_

Volunteer Preference (Children or Adults):

\_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Have you ever volunteered with Tammy Lynn Center?  Yes  No

If yes, list dates (month and year) \_\_\_\_\_

Age\* \_\_\_\_\_ Frequency of Volunteer Commitment: \_\_\_\_\_

Available Day(s): \_\_\_\_\_ Available Times: \_\_\_\_\_

Desired Start Date: \_\_\_\_\_ Desired End Date: \_\_\_\_\_

Date of last TB test\*\* \_\_\_\_\_

How did you hear about our organization: \_\_\_\_\_

Additional Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*\*Please note that volunteers under the age of 18 are considered minors and must be accompanied by an adult at all times while on campus.*

*\*\* Proof of valid TB test results are required for volunteers who wish to work directly with residents. Testing is available at Tammy Lynn Center for volunteers who have successfully completed necessary paperwork and met all applicable guidelines.*

**TAMMY LYNN CENTER FOR DEVELOPMENTAL DISABILITIES  
VOLUNTEER RECRUITMENT**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Company, School or Group Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

Have you volunteered at the Center in the past?     Yes     No

When are you available to begin volunteering? \_\_\_\_\_

Are you willing to make a time commitment of at least 6 months? \_\_\_\_\_

If not, how long? \_\_\_\_\_

What days and times of the week are you available? \_\_\_\_\_

Do you have reliable transportation? \_\_\_\_\_

Why do you want to volunteer at the Tammy Lynn Center? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all prior volunteer experience and/or any work experience related to developmental disabilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check the areas in which you have volunteer interest:**

- |                                      |   |                                    |  |
|--------------------------------------|---|------------------------------------|--|
| <input type="radio"/> Administration | <input type="radio"/> Day Services (school program) | <input type="radio"/> Fundraising  | <input type="radio"/> Special Events       |
| <input type="radio"/> Property Care  | <input type="radio"/> Residential Services          | <input type="radio"/> Respite Care | <input type="radio"/> Therapeutic Services |

**Please list an emergency contact:**

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_

**TAMMY LYNN CENTER FOR DEVELOPMENTAL DISABILITIES  
VOLUNTEER RECRUITMENT**

Please list one professional reference that isn't related to you:

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

Have you ever been convicted of a crime other than a minor traffic violation?     Yes     No

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

I certify all information given within this form is true, complete and correct. As a volunteer, I agree to abide by all rules and regulations of the Tammy Lynn Center. As a volunteer for an agency providing services to children, vulnerable adults and families, I certify that I have no criminal background or civil history that would be considered inappropriate.

I authorize the Tammy Lynn Center to conduct background checks as they determine appropriate in an effort to protect the clients served and the interest of the agency. This may include but is not limited to employment, military, financial, criminal and motor vehicle records. I authorize the release of such information from the parties holding such records.

\_\_\_\_\_  
SIGNATURE OF VOLUNTEER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

**TAMMY LYNN CENTER FOR DEVELOPMENTAL DISABILITIES  
VOLUNTEER HEALTH QUESTIONNAIRE**

**I. Contact Information**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**II. Personal History**

Please answer all questions. Comment on all positive answers in space provided.

Have You Had	Yes	No	Have You Had	Yes	No	Comments
Eye Trouble			"Trick" Knee, Back, Shoulder, etc.			
Ear, Nose Throat Trouble			Anemia			
Frequent/Severe Headaches			Frequent/Severe Respiratory Infection			
Epilepsy			Rheumatic Fever or Heart Murmur			
Asthma, Hay Fever, Hives			Stomach or Intestinal Trouble			
Tuberculosis			Infectious Mononucleosis			
Kidney/Bladder Disease			Diabetes			
Diseases or Injury of Bones/Joints			Hepatitis/Jaundice			
Infectious Hepatitis B						

Have You Had or Do You Have	Yes	No	Comments
Any drug allergy or other known sensitivity or intolerance? (Provide details.)			
Any physical/mental condition that might hinder your ability to perform responsibilities assigned to you?			

**III. Health Status**

I am in excellent physical health and am free of communicable disease. If not, please explain.

\_\_\_\_\_

\_\_\_\_\_

I take the following medications regularly. Please explain. \_\_\_\_\_

\_\_\_\_\_

I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. This health statement is accurate to the best of my knowledge. I will advise the Center if my health status changes.

\_\_\_\_\_

Volunteer Signature

Date

**IV. Tuberculin Test**

You will need proof of a **NEGATIVE TB Test** to volunteer here. If you have had a TB test within the past year, please provide proof from the medical facility where it was administered.

TLC OPERATIONS, INC.

739 Chappell Drive, Raleigh, North Carolina 27606 ♦ Telephone: (919) 832-3909 ♦ Personnel Fax: (919) 834-5837

Reference Requested by: \_\_\_\_\_

**CONFIDENTIAL PERSONAL REFERENCE**

Attention: \_\_\_\_\_  
Name

Date: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Fax: \_\_\_\_\_

\_\_\_\_\_  
Number/Street/City/State/Zip Code

**Applicant's Name:** \_\_\_\_\_

This person is applying for employment with the Tammy Lynn Center for Developmental Disabilities. We would appreciate your help in evaluating this candidate for the position of: \_\_\_\_\_  
Please complete and return this reference in the enclosed envelope. All information will be maintained confidentially.  
**Thank you for your cooperation and prompt response.**

**Applicant's Release**

I hereby authorize TLC Operations, Inc. to contact any former places of employment and/or persons who may aid the Tammy Lynn Center for Developmental Disabilities in determining my suitability for employment. Additionally, I release those individuals and/or organizations from all liability whatsoever for releasing the requested information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING:**

How do you know this person? \_\_\_\_\_

How long have you known this person? \_\_\_\_\_

Would you hire this person to work for you? \_\_\_\_\_ Please explain why: \_\_\_\_\_

Does this person **work well with others**? \_\_\_\_\_ Does this person show **initiative**? \_\_\_\_\_

Is this person **dependable**? \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To your knowledge, has the applicant had a record of criminal activity, excessive use of alcohol or other impairing drugs, mental illness, emotional problems or other conditions that might render him/her unsuitable for employment in a child care facility?  
 Yes  No

If "yes", please explain \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# TAMMY LYNN CENTER FOR DEVELOPMENTAL DISABILITIES CLIENT CONFIDENTIALITY FORM

## ACKNOWLEDGEMENT AND ASSURANCE OF CONFIDENTIALITY OF CLIENT INFORMATION

I understand applicable state and federal confidentiality regulations are on file in the Record Manager's office for my review. I agree to hold confidential all information to which I may have access about clients or former clients of the Tammy Lynn Center for Developmental Disabilities and will not divulge any information to unauthorized persons. I understand the divulging of confidential information about former or current clients to unauthorized persons will make me subject to civil action for monetary damages and/or suspension or dismissal.

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Signature of Volunteer

---

Witness Signature

---

Printed Name

---

Position

---

Signature of Parent/Guardian

---

Date

---

Date

---