State of California - The Resources Agency
DEPARTMENT OF PARKS AND RECREATION

VOLUNTEER SERVICE AGREEMENT

A copy of the volunteer duty statement must be attached.

NAME *(First, MI, Last)*	HOME PHONE NO.	ALTERNATE PHONE NO.
HOME ADDRESS	**CITY/STATE/ZIP CODE**	**EMAIL ADDRESS**

CHECK ONE

☐ I am 18 years of age or older. I am under 18 year of age *(Attach a signed Parental/Guardian Permission Form, DPR 208C.)*

SERVICE AGREEMENT

I agree to comply with all Department policies, regulations, directives and instructions, and to conduct myself in a professional manner, consistent with the same standards as established for Department employees.

I understand that I will not be compensated for any work performed as a State Parks Volunteer, other than for reimbursement of necessary and allowable expenses when authorized in my duty statement and in accordance with State rules. [Reimbursement requires that I complete an Oath of Allegiance (STD. 689).]

I understand that any injuries I sustain in the course and scope of performing authorized volunteer services under this agreement shall be included within the scope of workers' compensation coverage maintained by the Department, to the same extent as injuries sustained by a Department employee. I also understand that the Department may, at its discretion, assume liability for tort claims against me arising from my acts or omissions occurring within the course and scope of my authorized volunteer service.

I understand and agree that all rights, title and interest, including copyright, in and to any materials created by me as a volunteer during the term of this agreement shall belong to the Department upon creation and shall continue in the Department's exclusive ownership upon termination of this agreement. Such materials shall be a work for hire within the meaning of the Copyright Act of 1976, as amended. If and to the extent that any portion of the materials created by me pursuant to this agreement are determined not to be a work for hire, I assign to the Department all rights, title and interest in such portion of the materials, including all related copyrights and other proprietary rights. I agree that the provisions of this paragraph shall be effective unless otherwise agreed to in writing. I agree to cooperate with the Department and to execute any document reasonably necessary to give these provisions full force and effect, even if this agreement has been terminated.

I understand that this agreement remains in effect only so long as is mutually agreeable to both the Department and me, and that either I or the Department may terminate this agreement at any time, with or without cause, and with or without advance notice.

DISTRICT/DIVISION WHERE VOLUNTEER ASSIGNED	WORK LOCATION/PARK UNIT(S)	DATE VOLUNTEER TO BEGIN WORK
Russian River District	Russian River District State Parks	

VOLUNTEER APPROVAL: *I hereby volunteer my services as a State Parks Volunteer for the job duties attached.*	**DEPARTMENT APPROVAL** *(contingent on approval of appropriate forms)*
VOLUNTEER SIGNATURE ▶ DATE	DEPARTMENT REPRESENTATIVE SIGNATURE ▶ DATE

EMERGENCY NOTIFICATION

First

NAME	RELATIONSHIP	HOME PHONE NO.	ALTERNATE PHONE NO.
STREET ADDRESS		**CITY/STATE/ZIP CODE**	

Second

NAME	RELATIONSHIP	HOME PHONE NO.	ALTERNATE PHONE NO.
STREET ADDRESS		CITY/STATE/ZIP CODE	

DATE VOLUNTEER SEPARATED		DEPARTMENT REPRESENTATIVE SIGNATURE
	Revie☐ prior to reinstatement. Volu☐er in good standing.	▶

State of California - The Resources Agency
DEPARTMENT OF PARKS AND RECREATION

STATE PARKS VOLUNTEER APPLICATION

NAME *(First, MI, Last)*	HOME PHONE NO.	ALTERNATE PHONE NO.	EMAIL ADDRESS

STREET ADDRESS	CITY/STATE/ZIP CODE

IF UNDER AGE 18, PROVIDE NAME, ADDRESS AND PHONE NO. OF PARENT OR GUARDIAN

HAVE YOU EVER SERVED AS A CALIFORNIA STATE PARKS VOLUNTEER? ☐ Yes *(List locations and approximate dates below.)* ☐ No

POSITION YOU ARE SEEKING	PARK PREFERENCE, IF KNOWN

WHY DO YOU WISH TO BECOME A STATE PARK VOLUNTEER?

CURRENT OCCUPATION

HIGHLIGHT YOUR EDUCATIONAL AND EMPLOYMENT BACKGROUND/EXPERIENCES THAT YOU FEEL MAY CONTRIBUTE TO THE STATE PARK VOLUNTEER PROGRAM
(You may attach a resume.)

LIST THREE PERSONS NOT RELATED TO YOU WHO KNOW OF YOUR WORK QUALITY

Name	Phone No.	Relationship

FOR CAMPGROUND HOST APPLICANTS ONLY

INDICATE YOUR CHOICE OF STATE PARK AND DATES AVAILABLE *(Minimum of 30 days, maximum of 6 consecutive months in one park.)*

First Choice	Dates Available	Second Choice	Dates Available

INDICATE TYPE OF EQUIPMENT AND LENGTH

☐ Camper: ☐ Motorhome: ☐ Trailer: ☐ Extra Vehicle:

IF APPLICABLE, INDICATE TYPES AND NUMBER OF PETS YOU WILL HAVE WITH YOU *(You must have proof of your pets' current rabies vaccination with you while you reside in the park as a campground host.)*

☐ Dogs: ☐ Cats: ☐ Other:

CERTIFICATION

I understand that additional information, such as driver's license, Social Security Account Number and a background check may be required for certain volunteer positions. I hereby certify that all statements made on this application are true and complete.

Applicant Signature Date

▶

STD 910 (EST 1/2002) (FRONT)
ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

APPLICANT INFORMATION

LAST NAME	FIRST NAME	GENDER
		☐ MALE ☐ FEMALE
ADDDRESS	CITY STATE	ZIP CODE
DAYTIME TELEPHONE	EVENING TELEPHONE	
CLASSIFICATION	HIRING DEPARTMENT	
VIP, Volunteers In Parks Program	Parks and Recreation/North Bay District/Russian River Sector	

CONTACT INFORMATION

NAME	TITLE
	District Personnel
LOCATION	TELEPHONE
☐ Russian River Sector, PO Box 123, Duncans Mills, CA 95430	(707) 865-2391

LIST OF ESSENTIAL FUNCTIONS

Enter list of essential functions of the job from current duty statement here or attach duty statement:

See Duty Statement

ACKNOWLEGEMENT

I certify that the duties listed above represent the essential functions of the job and classification listed above

SUPERVISOR'S NAME	*SUPERVISORS SIGNATURE*	*DATE*
PERSONNEL OFFICER'S NAME	*PERSONNEL OFFICER'S SIGNATURE*	*DATE*

STD 910 (EST 1/2002) (BACK)
ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

APPLICANT INFORMATION

I certify that I have read the essential functions of the job listed on page 1 and considering my current health status (please check on of the boxes below):

☐ I am able to perform all of the essential functions of the job without a need for reasonable accommodation.

☐ I am able to perform all the essential functions of the job, but will require reasonable accommodation (please describe your requested accommodation in the Reasonable Accommodation section below).

☐ I unable to perform one or more of the essential functions of the job, even with reasonable accommodation.

☐ I am not sure if I am able to perform one of more of the essential functions of the job I have identified the functional limitations that I believe may limit my ability to perform the essential functions of the hob in the Request For Essential Functions Evaluation section below.

REASONABLE ACCOMMODATION (If necessary, you may attach additional pages)

For each essential function of the job for which you require reasonable accommodation, please describe the reasonable accommodation you are requesting:

REQUEST FOR ESSENTIAL FUNCTIONS EVALUATIONS (If necessary, you may attach additional pages)

I am not sure whether I have a physical or mental limitation that may prevent or otherwise impair me from performing the essential functions of the job. Below I have listed the essential functions in question and my specific functional limitations that I believe may prevent or otherwise impair me from performing the listed essential functions of the job. I authorize the hiring authority, if necessary, to refer this information to the State Personnel Boards Medical Officer, or his /her delegated, to determine my ability to perform the essential functions of the job with or without reasonable accommodation.

ACKNOWLEDGMENT

I certify that the information I have provided concerning my ability to perform the essential functions of the job is true and complete to the best of my knowledge.

APPLICANT'S NAME (PRINT OR TYPE)	APPLICANT'S SIGNATURE	DATE

State of California - The Resources Agency
DEPARTMENT OF PARKS AND RECREATION

DATE VISUAL MEDIA CREATED

VISUAL MEDIA CONSENT

NAME OF PERSON CAPTURED IN VISUAL MEDIA *(print)*

PRIVACY RIGHTS AND USE OF INFORMATION

I give the State of California, Department of Parks and Recreation (DPR) permission to make photographs, videotapes, films or other likenesses of me, my child or legal ward. I hereby grant to DPR the unrestricted right to copyright any of the above-mentioned materials containing images of me, as well as the unrestricted right to use and reuse them, with their caption information, in whole or in part, in any manner, for any purpose and in any medium now known or hereinafter invented. These rights include, but are not limited to, the right to publish, copy, distribute, alter, license and publicly display these materials and images for editorial, trade, marketing and/or advertising purposes. I also grant to DPR and its licensees the unrestricted right to use and disclose my name in connection with use of the above materials.

I understand and agree that I will not be paid for any use described above.

I also waive, and release and discharge the State of California, DPR, its officers, employees and/or agents from, any and all claims arising out of or in connection with any use of the materials, caption information and images described above, including any and all claims for libel, defamation and/or invasion of privacy or publicity. I realize I cannot withdraw my consent after I sign this form and I realize this form is binding on me and my heirs, legal representatives and assigns.

SIGNATURE ▶	PHONE NUMBER ( )
ADDRESS	CITY/STATE/ZIP CODE

IF THE ABOVE PERSON IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST COMPLETE THE FOLLOWING:

I am the parent or legal guardian of the person named above and I hereby sign this consent form on behalf such person in accordance with the statements above.

PARENT OR LEGAL GUARDIAN SIGNATURE ▶	PRINTED NAME	PHONE NUMBER ( )
ADDRESS	CITY/STATE/ZIP CODE	

FOR DEPARTMENT USE ONLY

IMAGE NUMBERS

_____ _____ _____ _____ _____ _____ _____

PURPOSE

This form is designed to protect the Intellectual Property Rights of the California Department of Parks and Recreation. It is also designed to protect the Department and avoid the violation of any privacy rights regarding display or use of visual media (i.e. still photography, video footage, etc.) featuring members of the public. Multiple copies of this form must be carried in the field whenever the creation of visual media may capture members of the public when said visual media displays members of the public in a recognizable way.

COMPLETION INSTRUCTIONS

General Instructions

Individuals captured in various visual media by California Department of Parks and Recreation employees must complete this form. This form must be completed while the employees are in the process of capturing visual media.

- ALL people captured in a particular shot must fill out a separate copy of the form.
- ONE person CANNOT sign for a particular group; however, multiple children can be included on one form if they share the same parent and/or legal guardian.
- A parent's or legal guardian's signature on a minor's form DOES NOT count as consent for use of the parent's/legal guardian's image as well.
- BE SURE that the form is properly completed before moving on to another shot.

Item Instructions

DATE VISUAL MEDIA CREATED: Enter the date the visual media is created (i.e., date photograph taken, date video footage filmed, etc.).

NAME OF PERSON CAPTURED IN VISUAL MEDIA: Have the person appearing in the visual media print his/her full name.

SIGNATURE / PHONE NUMBER / ADDRESS: Have the person appearing in the visual media enter his/her signature, telephone number and current address.

IF THE ABOVE PERSON IS UNDER 18 YEARS OF AGE: ***If the person appearing in the image is under the age of 18, his/her parent or legal guardian MUST complete this bottom section.*** The parent or legal guardian ***must enter ALL requested information for the form to be valid*** . If the form is not valid, the image is unusable.

PARENT OR LEGAL GUARDIAN SIGNATURE / PRINTED NAME / PHONE NUMBER / ADDRESS: Have the parent or legal guardian enter his/her signature, printed name, telephone number and current address.

DISTRIBUTION:
Original - Personnel File
Copy - Supervisor
Copy - Employee

State of California - The Resources Agency
DEPARTMENT OF PARKS AND RECREATION

EMPLOYEE'S/VOLUNTEER'S
PRE-DESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- The doctor is your regular physician who is either a physician who has limited his or her practice of medicine to general practice, or a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment and retains your medical records. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses; ***and***
- Prior to the injury you provided the Department with the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify the Department if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

EMPLOYEE PRINTED NAME *(First, MI, Last)*	
DIVISION	SECTION/DISTRICT/SECTOR

If I have a work-related injury or illness, I choose to be treated by the following physician:

PHYSICIAN'S PRINTED NAME AND TITLE *(M.D. or O.D.)*, OR MEDICAL GROUP	PHONE NO. ( )
STREET ADDRESS	CITY/STATE/ZIP CODE
EMPLOYEE SIGNATURE ✍	DATE

I agree to this predesignation.

PHYSICIAN SIGNATURE OR SIGNATURE OF DESIGNATED EMPLOYEE OF PHYSICIAN/MEDICAL GROUP* ✍ DATE

FOR ADMINISTRATIVE USE ONLY

RECEIVED BY	TITLE	DATE RECEIVED

* The physician is not required to sign this form; however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, Sections 9780.1(a)(3) and 9783.