

City of Wichita Volunteer Application – Accessible Parking Program

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Driver's License Number: _____

Required Materials

In addition to the completed application, please submit the following:

1. A copy of your valid driver's license
2. No less than three references from non-family members
3. Proof of transportation and continuing insurance

Description of Accessible Parking Program Volunteer Duties

A volunteer patrols parking lots photographing violations of the accessible parking ordinances, within the City of Wichita. Volunteers may request citations for displaying an expired handicapped placard, unauthorized parking in an accessible parking space, parking in an access aisle, or blocking an accessible parking space. The volunteer will report to, and be supervised by a law enforcement officer designated by the Chief of Police. The volunteer will appear and testify in court when requested by the City of Wichita Department of Law. Volunteers must consider equity and justice when photographing possible violations. It is vital to this program that volunteers strive to promote accessible parking for people with disabilities, but just as importantly serve as ambassadors for the City of Wichita.

Minimum Requirements For Volunteer Applicant:

1. High School Graduation or GED
2. Knowledge/skill in understanding and applying accessible-parking laws
3. Effective communication skills
4. Capability to identify a vehicle that is eligible to park in a designated parking space
5. Ability to take photographs of violations
6. Ability to handle situations of stress and/or confrontations by the public
7. Ability to attend court hearings as required
8. Must be at least 21 years of age
9. Must hold a valid Class "C" Drivers License
10. Must have transportation, and maintain at a minimum a continuous liability insurance policy in an amount as required by state law
11. Must be able to provide fuel for transportation while working as a volunteer
12. Must have a cell phone in possession while working as a volunteer
13. Must have no prior convictions, and be able to pass a background investigation
14. Must have no history of mental instability, anger management issues or competency issues
15. Must be able to write legibly
16. No more than two moving violation convictions, diversions, or being at fault in more than one accident during the past twelve months.
17. No convictions, or diversions, of any felony or misdemeanor crime(s).
18. Ability to donate at least six hours per month to the volunteer program.

City of Wichita Volunteer Questionnaire – Accessible Parking Volunteer

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

In the event of an emergency, please provide the following contact information:

Contact: _____ Phone Number: _____

1. Have you been convicted of driving under the influence within the past five years? Yes/No
a. If yes, please provide additional information _____

2. Have you been convicted of possession of illegal drugs within the past five years? Yes/No
a. If yes, please provide additional information _____

3. Have you violated any employer drug or alcohol rules within the past five years? Yes/No
a. If yes, please provide additional information _____

4. Have you ever been diagnosed with depression or another mental health disorders? Yes/No
a. If yes, please provide additional information _____

5. Have you ever been treated for anger management? Yes/No
a. If yes, please provide additional information _____

6. I hereby authorize release of information concerning alcohol abuse, drug abuse, mental health disorders, and anger management as part of a background check to be conducted by the City of Wichita. Any information acquired from the background check will be used only for consideration in the selection of volunteers for the Accessible Parking Program and will be strictly confidential.

Volunteer Signature: _____ Date: _____

Questions

1. *Briefly describe your interest in the Accessible Parking Program?*

2. *What characteristic is most important for an Accessible Parking volunteer?*

3. *Will you have any difficulties meeting or performing the program requirements? If so, why?*

4. *Provide your definition of justice as it relates to enforcing the accessible parking violations.*

5. *Describe your experiences interacting with individuals in a professional environment.*

6. *Describe an experience where someone was confrontational with you, and explain how you handled the situation.*

7. *Please note any additional information relevant to your participation as an Accessible Parking Program volunteer.*

**AUTHORIZATION FOR THE RELEASE OF HEALTH-RELATED INFORMATION PURSUANT TO THE
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

The City of Wichita requests this information for confirmation that this individual is able to handle the rigors of volunteering for the city's Accessible Parking Program. The volunteer position requires volunteers to be clearheaded, controlled, and free of any substance that would impair judgment and render the individual incapable of the clarity needed for a potentially confrontational and stressful position. The requested information is the minimum necessary to evaluate the candidate's potential for succeeding in the Accessible Parking Program. The City of Wichita will restrict access to this information specifically to the decision makers in charge of volunteer approval.

Name:	Date of Birth:	Social Security Number:
Address:		

I request that health information regarding my care and treatment be released as set forth on this form: in accordance with Kansas State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL ABUSE**, **DRUG ABUSE**, and **MENTAL HEALTH TREATMENT** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. I understand that once the requested information has been disclosed, it may be re-disclosed by the recipient, except as noted in Item 2 above, and the information may not be protected by federal or state privacy laws or regulations.
3. If I am authorizing the release of alcohol treatment, drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
4. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been based on this authorization. To revoke this authorization, the signor must send written notification to the Wichita chief of police or the designee overseeing the Accessible Parking Program.
5. I understand that signing this authorization is voluntary. I also understand that a refusal to sign an authorization may result in my not being approved as a volunteer in the Accessible Parking Program.
6. A photocopy/facsimile copy of this document may be used as an original.

7. This authorization expires once a disclosure has been made to the City of Wichita. This is a one-time authorization.
8. THIS AUTHORIZATION DOES NOT AUTHORIZE THE CITY OF WICHITA TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

AUTHORIZATION FOR THE RELEASE OF HEALTH-RELATED INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). THE FOLLOWING ENTITIES ARE AUTHORIZED TO MAKE THE REQUESTED DISCLOSURES:

9. Name and address of health provider(s) or entity to release this information:			
Health Provider A:	Health Provider B:	Health Provider C:	Health Provider D:
10. Name, job title, department and address of person(s) to whom this information will be disclosed for use:			
Lt. Darras Delamaide Wichita Police Department 455 N. Main 4 th floor Wichita, KS 67202			
11. Specific information to be released:			
Medical Record from (insert date) <u>09/01/2001</u> to (insert date) <u>Present</u> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, referrals, billing records, insurance records, and records sent to you by other health care providers Other: _____ Include: (Indicate by Initialing) _____ <u>Alcohol/Drug Treatment*</u> _____ <u>Mental Health Information*</u>			
<i>*Release of alcohol/drug treatment and mental health information includes assessment, diagnoses, treatment plans, test results, attendance, and discharge plans.</i>			

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the completed form.

_____ Date

Signature of Volunteer

MEDICAL RELEASE

I, _____, agree that the listed person,
_____, is both physically and mentally fit to perform
the duties of volunteer for the Wichita Police Department Accessible Parking Program.

Signature