



Please Print

Full Name _____ Gender _____ Race _____

Birthdate _____ Social Security Number _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Currently Enrolled In: Name of School _____

Current Year in School: freshman sophomore junior senior

Can you meet with a child once a week during the school year? Yes / No Email: _____

What motivated you to participate in Mentor Squad?

Do you have a preference as to?

the grade level of your match? _____ the race of your match? _____

Would you be willing to work with a physically or emotionally challenged child? Yes / No

How do you plan to get to the Mentor Squad school? _____

Please list three references (non-relatives) who have known you for more than one year you authorize us to contact who would evaluate your qualifications as a volunteer.

1) _____
Name Relationship to You

Phone Number Mailing Address/Zip Code

2) _____
Name Relationship to You

Phone Number Mailing Address/Zip Code

3) _____
Name Relationship to You

Phone Number Mailing Address/Zip Code



Mentor Agreement

As a volunteer for the Mentor Squad Mentoring Program, I agree to the following:

- Attend a training session before beginning.
- Be on time for scheduled meetings and notify the school office if I am unable to keep my weekly meeting.
- Engage in the relationship with an open mind.
- Accept assistance from my match's teacher.
- Keep discussions with my match confidential, unless to do so would endanger you or your match.
- Ask for assistance when I need help with my match.
- Notify the agency of changes in my address and phone number.
- Commit at least one hour a week for the school year.
- I will not use drugs or alcohol before or during the time I spend with my match.
- I will not initiate any contact with my match outside of school,
- I will not use physical discipline with my match.

I understand that as a volunteer mentor, I may be matched with a child and if so, I will commit to at least one hour a week for the school year. I know that my mentorship will take place **ONLY at a pre-assigned elementary school.**

Signature

Date

Your signature authorizes Mentor Squad to conduct a check of your criminal background to ensure participant's safety.

Signature

Date

Please return this completed application to:

Mentor Squad
600 S 2nd St., Suite 308
Bismarck ND 58504

701 222-0797 (phone) 701 223-5775 (fax)



CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
 CHILD ABUSE AND NEGLECT PROGRAM
 SFN 433 (1-2021)

Part I: Agency/Organization Information

Agency/Organization Bis-Man Mentor Squad	Contact Person Tami Lehr	Telephone Number (701) 222-0797	
Address 600 S. 2nd St., Suite 308	City Bismarck	State ND	ZIP Code 58504
Email Address and/or Fax Number tami@bismanmentorsquad.com			

Part II: Authorization for Release of Information (to be completed by the person giving consent/authorization)

- _____ (Initials) I give North Dakota Department of Human Services (NDDHS) and its' authorized agents (Human Service Zone agencies) permission to check the Child Abuse/Neglect Information Index for my name.
- _____ (Initials) I further give permission to NDDHS and its' authorized agents to release child abuse and neglect records pertaining ONLY to the services required decisions indicated below to the above-named agency/organization. **(NOTE: If this statement is not checked and initialed, and if child abuse and neglect records contain any medical, drug, alcohol, or mental health treatment information, an Authorization to Disclose Information Form (SFN 1059) will be required.)**

This information is being requested for: (Check Only One)				
<input type="checkbox"/> Employment with NDDHS	<input type="checkbox"/> Employment in a NDDHS Licensed or Contracted Agency	<input type="checkbox"/> Childcare/In-home Provider		
<input type="checkbox"/> Adoption Study	<input type="checkbox"/> Private Agency Employment/Volunteer	<input type="checkbox"/> Foster Parent Licensing		
<input type="checkbox"/> Other (List): _____				
LAST Name	FIRST Name	FULL MIDDLE Name <input type="checkbox"/> None <input type="checkbox"/> Initial Only	Social Security Number*	Date of Birth
Birth Name, Alias, or Other Married Names You Have Gone by in the Last Ten Years			OR <input type="checkbox"/> Check this box if you have no additional names	
Current Physical Address		City	State	ZIP Code
Last North Dakota Address		City	State	ZIP Code
Signature			Date	

* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is voluntary and is requested for identification purposes. Failure to disclose this information may result in a delay in reporting results.

This authorization remains in effect for 60-days from the date of signature unless specifically revoked by written notice to the agency/organization contact person. Any disclosure prior to a written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original.

Part III: Do Not Write Below - State Office Use Only

(NOTE: Results only include a search of the ND Child Abuse/Neglect Information Index. No tribal agency registry information is available through the state Index.)

- The above-named individual is not listed on the ND Child Abuse/Neglect Information Index.
- An assessment decision of Services Required was found on the ND Child Abuse/Neglect Information Index.
 For further details, please contact the Human Service Zone listed below.

Human Service Zone	Telephone Number	Email Address	Decision Date
Signature of Person Completing CA/N Information Index Inquiry		Submit the completed form to: Children and Family Services 600 East Boulevard Avenue, Dept. 325 Bismarck, ND 58505 (701) 328-2316 E-mail: dhscfs_cani@nd.gov Fax: (701) 328-3538	
Date Completed			



PERSONAL AUTHORIZATION FOR CRIMINAL HISTORY RECORD INFORMATION

OFFICE OF ATTORNEY GENERAL
BUREAU OF CRIMINAL INVESTIGATION
SFN 51156 (05-2021)

REQUESTER INFORMATION - RESULTS WILL BE MAILED TO INDIVIDUAL OR COMPANY INDICATED IN THIS BLOCK

Mail to Attention of Tami Lehr	Telephone Number 701-222-0797		
Name/Company Bis-Man Mentor Squad			
Address 600 S. 2nd St., Suite 308	City Bismarck	State ND	ZIP Code 58504

Pursuant to NDCC § 12-60-16.8, I hereby authorize the North Dakota Bureau of Criminal Investigation to release a copy of my criminal history record to the above party, provided; however, that the Bureau may release only that information pertaining to reportable events occurring within the past three years and information regarding any conviction.

Name (please print)	
Signature	Date

This form should accompany the Non-Criminal Justice Request for Criminal History Record Information. Both forms should be forwarded to the following address:

North Dakota Bureau of Criminal Investigation
Criminal Records Section
PO Box 1054
Bismarck ND 58502-1054
(701) 328-5500