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 <u>three references (non-relatives)</u> 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD ABUSE AND NEGLECT PROGRAM
SFN 433 (12-2022)

Clear Fields

The North Dakota Child Abuse/Neglect Information Index is mandated by the North Dakota Child Abuse and Neglect Law. When a decision is made that services are required or that child abuse or neglect is Confirmed, the names of individuals identified as the subject of the child abuse or neglect assessment are entered into the Index. The names remain on the Index for ten years from the date of the Services Required or Confirmed assessment decision. Results only include a search of the North Dakota Child Abuse/Neglect Information Index. No tribal agency registry information is available through the state Index.)

* 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.

Part I: Information of Individual Whose Name is to be Searched

LAST Name	FIRST Name	FULL MIDDLE Name ☐ None ☐ 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** ☐ Check this box if you have no additional names

Current Physical Address	City	State	ZIP Code
Last North Dakota Address	**City**	**State**	**ZIP Code**

Part II: Agency/Organization Information

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

Email Address and/or Fax Number
tami@bismanmentorsquad.com

This information is being requested for: **(Check Only One)**

☐ Employment with HHS ☐ Employment in a NDDHS Licensed or Contracted Agency ☐ Childcare/In-home Provider
☐ Adoption Study ☐ Private Agency Employment/Volunteer ☐ Foster Parent Licensing
☐ Other (List): ____________________

Part III: Consent

This consent remains in effect for 90-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 shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. **This document must be physically signed by the applicant or signed with a Public Key Infrastructure (like VeriSign or DocuSign). A typed signature is not accepted.**

a. I grant permission to the Department of Health and Human Services and its authorized agents (Human Service Zones) to conduct a search of my name on the North Dakota Child Abuse/Neglect Information Index and to disclose the results of the search to the agency/organization indicated on this form.

Signature	Date

b. I further authorize the Department of Health and Human Services and its authorized agents (Human Service Zones) to disclose the records of all Child Abuse and Neglect records pertaining to Services Required or Confirmed findings to the agency/organization indicated on this form. I understand that this information may include medical and mental health information.

I understand that substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent. Substance use disorder record information will not be disclosed unless an Authorization to Disclose Information form (SFN 1059) permitting the disclosure accompanies this form.

Signature	Date

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