

**Volunteer Services Application**  
Kansas State School for the Deaf  
450 East Park Street – Olathe, KS 66061-5497  
KSD IS A SMOKE FREE CAMPUS  
Website: <http://ksdeaf.org/About/Employment/>

**(Print or type using black pen & complete all information)**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Last First Middle Street Apt. # City State Zip

Tel. #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

**Volunteer Experience:** \_\_\_\_\_

Dates: (Years) \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

Description of Work:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employment Experience:** \_\_\_\_\_

Dates (Years) \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

Description of Work \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

May we contact your current/past employer(s)? \_\_\_\_\_

**Days Available:** Sun. Mon. Tue. Wed. Thu. Fri. Sat.

Morning: \_\_\_\_\_ Afternoon: \_\_\_\_\_ Evening: \_\_\_\_\_

Interests, Skills: \_\_\_\_\_

Education: (Circle highest grade) 8 9 10 11 12

College: 1 2 3 4 Graduate Post-Graduate

Major Subjects: \_\_\_\_\_

Type of Volunteer Work Preferred: \_\_\_\_\_

Date Available to Start: \_\_\_\_\_

Give a brief explanation as to why you would like to be a volunteer at K.S.D.

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Which department do you wish to volunteer for: \_\_\_\_\_ (if known)

Referred by: \_\_\_\_\_ (if known)

Who will be your supervisor you report to: \_\_\_\_\_ (if known)

What level of Sign Language communication skills would you say you have:

None    Basic    Fluent    Interpreter    (circle one)

Do you use: ASL or a sign system: CASE, PSE, SEE, etc. (circle one)

Have you ever been convicted of a felony? \_\_\_\_ If yes, please explain:

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Are you currently legally authorized to work in the United States? yes \_\_\_\_ no \_\_\_\_

Drivers License #: \_\_\_\_\_ State \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**(Must provide copy of Drivers License and Social Security Card)**

In case of emergency, contact: \_\_\_\_\_  
Name Relationship

Address City State Zip

Day phone Evening phone Other ways to contact?

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is CAUSE FOR DISMISSAL. Further, I understand and agree that my service is for no definite period and may be terminated at any time for good cause without any previous notice. I understand that I am required to abide by all rules and regulations of the Kansas School for the Deaf. I also understand that my application will be reviewed by the Volunteer Services Director and Volunteer Services Committee Members, and I will undergo an SRS, KBI, and Local Security Clearance.

Signature \_\_\_\_\_

Date \_\_\_\_\_



Kansas Department of Social and Rehabilitation Services  
Child Abuse and Neglect Central Registry  
PO Box 2637  
Topeka, KS 66601

Child Abuse and Neglect Central Registry  
**Release of Information**

I, \_\_\_\_\_, give permission for the release of any information concerning  
(please print complete first, middle and last name)  
myself in the Child Abuse and Neglect Central Registry to:

Contact Person: Warren Hurst or Teresa Chandler

Agency Name: KS School for the Deaf

Mailing address: 450 E Park St  
01athe KS 66061-5497

Phone Number ( 913 ) 791-0573

I understand that all information released will be for the exclusive and confidential use of the above named organization/person/agency.

☆☆ Please complete the information below by printing in ink. ☆☆  
Please print legibly. Do not leave any space blank. All requested information is required to process this request. Incomplete information will result in the release not being processed and will be returned as insufficient.

First, Middle and Last Name: \_\_\_\_\_

Maiden Name: (Female applicant only) \_\_\_\_\_

Married Names, Nicknames or Other Names Used:  
(Use N/A if no other names used.) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Race: \_\_\_\_\_

Social Security # \_\_\_\_\_

Gender:

Male

Female

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

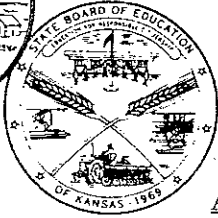
Date: \_\_\_\_\_

Current Address: \_\_\_\_\_

Each request must be submitted with payment prior to the request being processed. Please attach appropriate fee of \$10.00 per release of information. All releases and fees should be sent via postal mail to the attention of SRS, Child Abuse and Neglect Central Registry, P.O. Box 2637, Topeka, KS 66601. The following state agencies are exempt from the \$10.00 fee: JJA, KNI, Dept. Of Education-Central Office, KDHE, State Hospitals, State Correctional Institutions, Attorney General's Office, Kansas School for the Blind, Kansas School for the Deaf, Child Welfare agencies in other states.

For Central Registry Use Only

\_\_\_ FEE ATTACHED



**KANSAS STATE SCHOOL FOR THE DEAF**

OVER A CENTURY OF SERVICE. ESTABLISHED 1861.

450 EAST PARK STREET  
OLATHE, KANSAS 66061-5497  
TELEPHONE (913) 791-0573  
FAX (913) 791-0577

AUTHORIZATION FOR RELEASE OF INFORMATION

Identifying Code No. 902KS3481

I hereby request and authorize the Kansas Bureau of Investigation to furnish the Kansas State School for the Deaf with criminal history information as described in K.S.A. 22-4701 (b), as amended. This includes all information defined with K.A.R. 10-9-1 (b), (c), and (d), as amended.

I voluntarily waive all right of recourse and release the KBI from liability for compliance with this authorization.

PRINT FULL NAME: \_\_\_\_\_  
Last First Middle Name

CURRENT ADDRESS: \_\_\_\_\_  
Street City State Zip Code

ANY OTHER NAMED USED[i.e. AKA/Maiden Name]: (If not, please enter "none")

\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ SEX: \_\_\_\_\_

RACE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDITIONAL INFORMATION: (If not, please enter "none")

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE DATE

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KBI RESPONSE:

\_\_\_\_\_

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