



CO YLF June 29th-July 3rd Denver University, Denver CO

COLORADO YOUTH LEADERSHIP FORUM

ONSITE STAFF VOLUNTEER POSITION DESCRIPTIONS

Qualifications for all CO-YLF Staff:

All staff who work directly with the delegates must have an ADA¹ defined disability or have experience working with people with disabilities.

Volunteers must be 18 years of age; preference will be given to YLF alumni from other states and adults with disabilities who have worked with an independent living center or other organizations that provide advocacy or other direct services to students and youth with disabilities.

Minimum qualifications:

- Relevant education/training and/or equivalent experience working directly with people with disabilities.
- A minimum of 1 year providing services to youth and young adults with disabilities; past experience with residential services to people with disabilities preferred.

Volunteers must be able to work in a team-oriented environment, have excellent and compassionate communication skills.

All volunteer and paid staff are expected to:

- Demonstrate sensitivity to, and understanding of, individuals from diverse disability, socioeconomic, cultural, and ethnic backgrounds.
- Demonstrate flexibility and the ability to multitask.
- Demonstrate professionalism, including the ability to stay positive and be respectful to all.
- Be a positive role model.
- Be a team player and work together with other YLF staff.
- Be aware of the possibility of bullying, prevent and intervene if necessary.

¹ An individual with a disability is defined by the ADA as:

- a person who has a physical or mental impairment that substantially limits one or more major life activities (also known as “activities of daily living”),
- a person who has a history or record of such an impairment, or
- a person who is perceived by others as having such an impairment.



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- Be responsible to help ensure the safety and security of delegates and other staff members.
- Assist with emergency evacuation procedures as needed during the day or night.

All volunteers must participate in a formal YLF staff orientation prior to working onsite, and must remain onsite 24/7, live in a campus dormitory, and eat with the delegates in the campus cafeteria for the duration of the 6-day program.

All candidates must have a current background check.

ONSITE VOLUNTEER APPLICATION FORM

(All application information will be held in strict confidence and only used by the CO-YLF recruiting staff to determine your qualifications for the position you are applying to fill.)

Please complete this application form or use whatever communication method that is needed to respond to the requested data. Contact us at silcylf@coloradosilc.org if another type of accommodation is needed.

Print Name _____ With what Gender do you identify? Male
 Female Other: _____

Date of Birth: _____

Mailing Address _____

Email Address _____

Business telephone _____ Home/Cell telephone _____

Fax Number _____ YLF Alumni? _____ Year/Location: _____

Position Desired #1 _____ #2 _____

Qualifications for Position Desired

1. Education (last grade completed or degree) _____
2. Profession and current employer _____
3. Other special skills (related experience, ASL, Spanish proficiency, familiarity with disabilities) _____
4. Mentoring/Peer Counseling and Leadership experience _____



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Please briefly state why you would like to serve as a YLF volunteer staff: _____

Do you consider yourself to be a person with a disability? Y / N / Prefer not to answer

- Have you had a background check completed recently? Y / N
 - o When By whom
- Do you have a Mandatory Reporter certification? Y / N
 - o When By whom
- Do you have a current FA/CPR certification? Y / N
 - o When By whom
- Have you ever worked in a residential setting with people under 18? Y / N Over 18? Y / N
 - o If yes, briefly describe:

Please provide a personal reference (name + telephone + email) _____

Have you served as a YLF staff member before? No Yes

Year(s) _____ Location _____

I have attached a current resume

If this application is accepted, I understand that false or misleading information in my application or interview may result in my immediate termination as a CO-YLF volunteer.

Signature _____

Date _____



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MEDICAL INFORMATION AND ACCOMMODATIONS

PART I: INFORMATION

Last Name *First Name* *Middle Name*

Street Address *City* *Zip Code*

Home Phone (_____) Cell Phone (_____)

Email: _____ Work Phone (_____)

Date of Birth _____

Communication Preference (please select one):

- Home Phone Work Phone Cell Phone (Talk)
- Cell Phone (Text) Email

PART II: REQUEST FOR ACCOMMODATIONS

To assist us in providing the appropriate accommodations for you, please describe your disability or medical condition and list what accommodations you may need. You may use additional paper.

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Blind/Visual <input type="checkbox"/> Braille <input type="checkbox"/> Large Print (font size____) <input type="checkbox"/> Audio Description | <ul style="list-style-type: none"> <input type="checkbox"/> Deaf/Hearing <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Real Time Captioning <input type="checkbox"/> Other (specify) |
|--|---|



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- Other (specify)



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- Communication Disability:** please tell us the specifics of your disability and how we can assist you:

- Learning Disability:** please tell us the specifics of your disability and how we can assist you (such as reading or writing):

- Emotional/Psychiatric Disability:** please tell us the specifics of your disability and how we can assist you:

- Mobility Limitation:** please tell us the specifics of your disability and how we can assist you:

Can you easily walk up stairs (to second floor lodging)?

- Yes No

- Wheelchair user (circle one): Manual or Motorized

- Special Equipment** needed that I **will** be bringing:

- Special Equipment** needed on-site that I **will NOT** be bringing:



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Personal Care Attendant needed. (Specify, in detail, what activities of daily living (ADL's) that you will require assistance with, who helps you, and how often you need assistance):

***NOTE: We will provide whatever appropriate assistance you request in advance to accommodate your disability.**

PART III: MEDICAL INFORMATION

Medical Insurance Plan Name:

Policy Holder_____ Policy Number _____

Family Physician _____ Telephone _____

***Please send a copy (back and front) of your insurance card with this form.**

Doctor's Care - Are you currently under a doctor's care? If yes, please specify for what condition(s):



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Colorado Statewide Independent Living Council
1-303-902-5897
silcyf@coloradosilc.org



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Medications - Are you currently taking any prescribed medications AND you need assistance with your medication? If yes, list the name of the medication, dosage, and schedule *ONLY if you need assistance with your medication:*

<u>Medication Name</u>	<u>Dosage</u>	<u>Schedule</u>	<u>Notes</u>

First aid supplies and over the counter medication is available to students when medically needed (such as): acetaminophen (Tylenol), ibuprofen (Advil), aspirin, Benadryl, Sudafed, cough drops, Ex-lax, and Pepto-Bismol. Please note, over the counter medication is dispensed at the discretion of medical staff per package directions (unless written directives are provided by a physician).

Allergies - Please list any medication(s), food(s), latex, etc. you are allergic to or have known reaction or contra indication to:

Dietary Restrictions - Please list any dietary restrictions:



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PART II: MEDICAL EMERGENCY - Person to notify in case of medical emergency:

Name _____ Relationship _____

Street Address *City* *Zip Code*

Home Phone () _____ Cell Phone _____

Email: _____ Work Phone () _____

Communication Preference (please select one):

- Home Phone Work Phone Cell Phone (Talk) Cell Phone (Text) Email

PART V: MISCELLANEOUS INFORMATION

What is your T-Shirt size: Small Medium Large XL XXL

Other (Please specify: _____)



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If there is any additional information you feel we should know, please list: