

# RETURNING COUNSELOR APPLICATION



Submit by email to [Glenda.Streicher@dciinc.org](mailto:Glenda.Streicher@dciinc.org)  
or by fax (615) 341-8814 to Attn: "Camp O Processing Dept"

NOTE: If you will be working in the hemodialysis unit, you MUST submit a copy of your current nursing or medical license, CPR certification, annual infection control training education documentation and hepatitis status.

**\*\*\*All staff MUST provide COVID vaccine documentation (two shots and one booster) and a negative PCR test within 72 hours of arriving at camp.**

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

## Counselor Information

Name (First, Last, MI) \_\_\_\_\_

Gender \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

T-shirt Sizes:      XS      S      M      L      XL      2XL      3XL

Staff Preference (select one):

Cabin Counselor

Hemo Staff

Logistic team (lodge)

PD Staff

City Group:

Card. Glennon - St. Louis

Lebonheur - Memphis

Vanderbilt

Cincinnati Children's Hospital

Nashville

Other \_\_\_\_\_

Dell Children's Medical Group

Texas Children's Hosp - Houston

Health issues: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Special needs/arrangements for me to be with my group kids: \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

**You will receive a separate email from CareerBuilder Employment Screening regarding your required background check. Please check spam mail if you do not get this email.**

# COUNSELOR CONTRACT



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## A Note to Potential Counselors

Counselor applications will be screened and accepted or rejected by camp directors. Background checks will be checked for all non DCI employee counselors. You will be notified of this decision prior to the start of camp. This process is to ensure that counselors who are approved to attend are committed to share in the work necessary to provide a positive camping experience for the children.

If you are driving, a valid drivers license and proof of insurance must be available. This is part of the application approval process.

Each counselor must complete a counselor application each year. The counselor contract and the rules and responsibilities form must be signed and included with the application. Please remember that we agreed that each city group coming to camp must provide a minimum ratio of **1 male counselor per every 4 male campers from your group**. Please limit your number of female counselors.

There will be a mandatory counselor orientation on Saturday after dinner for new and old counselors. In addition, nightly counselor meetings assignments will be provided in your cabins.

We are glad you are interested in Camp Okawehna. We look forward to seeing you at camp!

## Counselor Contract

I have completed and signed my camp counselor application.

I understand the camp history and mission statement. I have read the above note to potential counselors. I realize that my application may be denied and I will be notified accordingly.

I give permission to Dialysis Clinic, Inc (DCI) to take video footage and photographs of me during my time at camp. I understand and agree that the video footage and photographs or any part thereof may be used on television in newspapers, magazines, social media or in any other medium that DCI may choose, and, I, hereby release my likeness for said use by DCI.

I understand that I will not have any ownership or property rights in any video footage, photographs or any products or any product created therefrom. I also understand that I will not receive any compensation or money for the use of the video footage and photographs.

I have had the opportunity to ask questions, and I give my consent freely and voluntarily for DCI to use the video footage and photographs.

I agree to abide by the contract and rules provided to me for review.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# ACKNOWLEDGMENT OF DRIVING RESPONSIBILITIES RELATED TO TRANSPORTING CAMPERS



Submit by email to [Glenda.Streicher@dciinc.org](mailto:Glenda.Streicher@dciinc.org)  
or by fax (615) 341-8814 to Attn: "Camp O Processing Dept"

**\* Only required if you will be transporting campers.**

## Driver Information

Name (First, Last, MI) \_\_\_\_\_

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

Drivers License No. \_\_\_\_\_ State \_\_\_\_\_

I understand that driving minor children to and from Camp activities is a serious matter. I agree to adhere to the following driving guidelines that have been established for the safety of the children who reside at Camp Okawehna.

I will ensure that all children are restrained in the car according to Tennessee state law which states that children under four years old or forty pounds must be in a car seat. I will ensure that all other children are wearing a seatbelt. I will not put a child in the front seat of a car if there is a front seat airbag.

I understand that campers may only be transported on camp grounds by vehicles either owned or rented by Dialysis Clinic, Inc. (DCI) or a company under the same management umbrella as DCI. DCI owned or rented vehicles must be driven by DCI employees only.

I understand that City groups that rent their own vehicles may drive their campers (originating from their city group) on the camp grounds, but may not transport campers from outside their city group.

I will only drive a minor child or other Camper of the Cedar Crest property to attend an approved off-site camp activity or to seek emergency medical treatment, with the company of another adult.

I will only use a rental vehicle, not a personal vehicle, for transporting residents of Camp Okawehna. I verify that I have a valid driver's license and liability auto insurance that covers personal injury and damage to other property. I understand that if I am driving and involved in an automobile accident, that injures someone or causes property damage, then my personal auto insurance will be the primary coverage for the vehicle. I understand that DCI will reimburse the insured's deductible amount for the claim up to \$500.00.

I understand that I may not drive residents of Camp Okawehna unless I sign this form and attach my valid drivers license and proof of auto insurance. This form and attachments will be provided to Shannon Jamison, Director of Insurance & Worker's Compensation for Dialysis Clinic, Inc.

Signature Camp Driver \_\_\_\_\_ Date \_\_\_\_\_

Camp Driver (Print Name) \_\_\_\_\_



## CAMP OKAWEHNA CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_, a volunteer of Camp Okawehna ran by DCI acknowledge and agree as follows:

### **I. Protected Health Information**

1. For purposes of this Agreement, the term “Protected Health Information” means any information, whether oral or recorded, in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2. I understand that Camp Okawehna/DCI’s patients have a reasonable expectation of and a legal right to privacy concerning their Protected Health Information. I further understand that both Camp Okawehna/DCI and I have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their Protected Health Information.

3. In the course of my volunteer time at camp, I may come into contact with the Protected Health Information of camp patients (DCI’s Protected Health Information”). I agree that for the term of my volunteering with camp and at all times thereafter:

- a. I will maintain the confidentiality of Camp/ DCI Protected Health Information;
- b. I will not view, access or otherwise use or disclose any of DCI’s Protected Health Information except as is necessary to perform my job responsibilities or as required by law; and
- c. I will not discuss Camp/DCI’s Protected Health Information where others may overhear the conversation (for example, in hallways, on elevators, at lunch, on public transportation, at social events).

4. I further agree that I will comply with all Camp Okawehna policies and procedures that concern the security and privacy of DCI’s Protected Health Information.

### **II. Business and Proprietary Information.**

1. I understand that as a volunteer of Camp Okawehna/DCI, I may be exposed or have access to sensitive and confidential information concerning Camp/DCI and its business (“business and proprietary information”). This business and proprietary information includes, but is not limited to, information or data concerning patients, health care entities doing business with Camp/DCI, volunteers of Camp Okawehna/DCI or any of its subsidiaries or affiliates, physicians or other health care professionals performing services for DCI, financial information, business plans, contracts with third parties, and

all other proprietary information and trade secrets which are in the possession of Camp Okawehna/ DCI or any of its subsidiaries or affiliates.

2. Unless certain business and proprietary information is already known to or by the public, or I am required by law to reveal it, I agree, for the term of my volunteering with Camp Okawehna/DCI and for two (2) years thereafter, not to reveal any business and proprietary information of Camp Okawehna/DCI, use business and proprietary information of Camp Okawehna/DCI to the disadvantage of Camp Okawehna/DCI, or use business and proprietary information of DCI for the advantage of myself or of a third person unless Camp Okawehna/DCI consents after full disclosure.

3. I also understand that, depending on my job responsibilities, it may become necessary for me, during the course of my volunteering with Camp Okawehna/DCI, to have access to certain health records and information on other DCI employees, their dependents and other individuals who are insured through Camp Okawehna/DCI (“Insured Persons”). I agree that for the term of my volunteering with Camp Okawehna/DCI and at all times thereafter, I will maintain the confidentiality of the health records and information of these Insured Persons and will not release these records or reveal the information to any third party, except as expressly authorized by Camp Okawehna/DCI or as required by law after notice to Camp Okawehna/DCI.

### **III. Miscellaneous.**

1. I understand that my violation of this Agreement will subject me to corrective action, up to and including termination of employment. I also understand that Camp Okawehna/DCI may, within its sole discretion, advise appropriate officials of any illegal violations on my part and that Camp Okawehna/DCI may take legal action of its own for any damages it suffers as a result of my violation of this Agreement.

2. I agree that nothing herein shall be construed to be an employment contract between Camp Okawehna/DCI and myself. Additionally, I agree that nothing in this Agreement is to be construed as conferring any employment rights on me or changing my status from that of an “at-will employee.” I understand that Camp Okawehna/DCI retains the absolute right to refuse to allow me to return to camp, at any time, with or without good cause.

3. I agree that the provisions of this Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee.

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**Date**

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**Staff Signature**

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**Printed Staff Name**

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**Date**

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**Witness Signature**

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**Printed Witness Name**