



Dear Applicant,

Thank you for taking the first step on an adventure that will change your life as well as others! Please read and follow these instructions carefully and email Beth at beth@sight.org or call Beth at 903-717-7227 if you have any questions.

Things to Know Before Applying:

All Applicants:

- Applicants must be at least 18 years old at time of service.
- All forms should be completed in English. Please type or print legibly using black ink.
- The minimum time of service is 2 weeks, but some exceptions may be made under special circumstances.
- Due to given circumstances; those with certain disabilities and/or health histories may not be able to serve with Sight.org in Africa.
- A current *Personal Health History*, *Physical Evaluation*, and *Immunization Checklist* are required for all Applicants.
- A recent (non-Sight.org) physical evaluation (completed within the last 12 months) *may* be acceptable *if* there has been no change in your health history since the evaluation was completed and the form provides enough information to establish a sound medical review.
- All Applicants are required to provide/raise their own funds to cover crew fees, insurance, and transportation to and from Togo, Africa, as well as all other personal expenses. If you apply for and accept a position, you will be responsible to ensure that adequate funding is in place before joining.
 - If you need materials to help with your fundraising efforts, please let us know.
- Three references are required prior to acceptance. However, if you are not able to provide an Employer or Pastor/Spiritual Leader reference, you should explain why and supply a substitute reference from someone who has functioned in a supervisor or mentoring role for you.
- Once we receive your completed application, we will review it in light of our open positions, housing availability, and your qualifications. Processing is usually done in four to six weeks.
- A phone call or meeting will likely be requested by one of our staff during the application evaluation process.

Medical Professionals:

- Required to be licensed and have 2 years of post-licensed experience.
- Include copies of current resume or CV, diploma, license, and relevant certifications with completed application.
- If you currently hold defined clinical privileges at a hospital or other health care facility, please include a copy of your current active privileges.
- Please use the **Medical Professional Reference form** instead of the **Employer's Reference form**.

Couples & Families:

- Housing for couples and families are provided to accommodate for short-term and long-term family services.
 - Due to the difficulty in finding short-term housing, however, short-term family volunteers may stay in the comfortable "bunkhouse" atmosphere of our ministry headquarters.
- Due to staffing limitations, we are not able to accommodate for single parent families with children under the age of 15 or families with more than 4 children.

When complete, please make a copy and send it to us by mail or email to the information listed below:

Mail: Sight.org
PO Box 8286
Tyler, Texas 75711 USA

Email: beth@sight.org



Application

Office use only

Vista#

Legal Name: _____
 (last/surname) (first) (middle) (preferred)

Permanent Address: Street: _____
 City: _____ State: _____ Zip/Postal Code: _____
 Country: _____ Is this also the country where you pay taxes? Yes No
 Email: _____

Phone Numbers: Home: _____ Work: _____
 (include Country Code)
 Cell/Mobile Number: _____

Date of birth (month/day/year): _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<input type="checkbox"/> Single	If Separated, Divorced, or Widowed, when: _____ (month/year)
If married, is your spouse applying? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's name: _____

I am applying for:	<input type="checkbox"/> A Volunteer Position with Sight.org in Togo, Africa. <input type="checkbox"/> Foundations of Sight.org (Tyler, Texas)
I am applying to serve: Indicate length of time in weeks, months, or years	_____ (Weeks/Months/Years)
Dates available:	From: (month/day/year) _____ To: (month/day/year) _____
Position(s) applying for (required): Go to Sight.org/volunteer for a list of available positions on our Current Opportunities webpage.	
Families: How many children will accompany you?	

Please answer the following questions: If you reply "yes" to questions 4-7, please explain on a separate piece of paper.

- Yes No 1. Are you aware that Sight.org is a volunteer, faith-based, non-salaried organization?
- Yes No 2. Do you have any relatives/friends who have served with Sight.org?
- Yes No 3. Are you able to provide/raise the financial support necessary to serve with Sight.org?
- Yes No 4. Have you ever been convicted of a criminal offense?
- Yes No 5. Have you ever been a subject of any claim or complaint, any investigation, or any disciplinary or remedial action of any kind by any entity, organization, association, church, court, or governmental authority involving allegations of dishonesty, deceit, fraud, abuse, or mistreatment (physical, sexual, or emotional) of any kind of any other person, or any other act of immoral behavior?
- Yes No 6. Have you ever engaged in any misconduct, or been a subject of any allegations of misconduct, involving the abuse, mistreatment (physical, sexual, or emotional), or neglect of a child?
- Yes No 7. Are there any circumstances (medical or other) which could interfere with your meeting the requirements of the position for which you are applying?

Medical professionals, please answer the following: If you reply "yes", please explain on a separate piece of paper.

- Yes No 1. Have you ever been named in a medical malpractice claim?
- Yes No 2. Have you ever been denied medical staff appointment or had your clinical privileges suspended, limited, revoked or renewal denied?

- Yes No 3. Have you ever voluntarily or involuntarily withdrawn, reduced, terminated, lost or been denied your clinical privileges?
- Yes No 4. Have there been any successful or currently pending challenges, investigations, revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial or with-drawl to any licensure, certification, or registration to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?.

Education/Job History: If applying for a medical position, please attach a current résumé or C.V. For all other positions, please complete the following or attach a current résumé or C.V.

Education: Please list schools (secondary/high school/technical/college/university/seminary) you have attended.

Name of school	Location	Dates attended	Diploma/Degree

Professional Licenses or Certificates: Please list current professional, medical, technical, or marine licenses/certificates you hold. Please include copies with your application.

Type/class	Nationality/State

Work Experience: Please list your last 3 employers.

Employer	Position	Dates served
1.		
Address:		
2.		
Address:		
3.		
Address:		

Skills Checklist: Please check the skills listed below which you feel you are most qualified to use in Sight.org.

- Administration (Receptionist, Executive Assistant, HR Generalist, Data entry, etc.)
- Accounting (Accountant, Bookkeeper, clerk, etc.)
- IT (Computer Programmer, AV Tech, Systems Analyst, etc.)
- Other Business Professional _____
- Medical Professional
- Communications (Print, Media, Videographer, Public Relations, Graphic Design, etc.)
- Other (please list below)

Please list any other talent, skill, certification, or professional qualification you'd like us to know about:

Language Skills:

Language	Conversational Ability to handle basic communications	Proficient Ability to converse and comprehend in-depth conversations	Fluent Equivalent to a native speaker
English:			
French:			

Other:			
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Personal Profile:

How did you hear about Sight.org?

- Website Friend Magazine News TV News Paper Conference Church Other

If so, which one? _____

Please describe any experience you have living/working outside of your own culture:

What is the name of the church you currently attend and what is your involvement there?

Please explain why you wish to serve with Sight.org:

MY TESTIMONY

Write a paragraph using answers to the questions below. Please write in story form and not just as answers to the questions. The typing field will enlarge as you type more information. If you are handwriting this, please use extra sheets to complete the questions.

- What was my life like before I met Jesus Christ? (What were my needs? What got me interested in God?)
- How did I come to know Jesus Christ as my Savior? (Who was I with? When did this happen? What did I say to God?)
- What is my life like with Christ now? (What needs does Jesus meet? How is my life different? How is my faith growing?)

Acknowledgements/Authorization

I hereby consent and authorize an investigation of my past and/present employment and for Sight.org to conduct a background check relative to any matters contained in my application and any matters relevant to consideration of my service by Sight.org. I hereby waive any and all notice of disclosures required by my past and present employer(s).

In consideration of possible service by Sight.org, I hereby release and forever discharge Sight.org, my past /present employer(s) and their respective parents, subsidiaries, and successors from any and all actions, which may result from any information that is lawfully provided concerning my past employment and /or present employment. I certify that all statements given on this application are correct with no omissions.

I acknowledge that if I am unable to serve with Sight.org, any funds processed on my behalf will remain the property of Sight.org and will be directed to the Sight.org General Fund if I do not reapply to serve within 18 months. I further understand that any funds processed on my behalf in excess of the direct cost of my service may remain with Sight.org.

Applicant Signature

Date (month/day/year)

Printed name

Personal I.D. or Social Security Number

Sight.org Associates is an Equal Opportunity Employer, and conducts hiring without regard to race, color, ancestry, citizenship, age, sex, marital status, or disability of an otherwise qualified individual. In addition to being a 501(c)(3) tax-exempt corporation, Sight.org is also a faith-based religious organization. As a faith-based religious organization pursuant to the Civil Rights Act of 1964, 78 Stat.255, Section 702 (42 U.S.C. @2000e), Sight.org has the right to deny acceptance to those who do not agree and fully attest to our Statement of Faith and Sight.org Code of Conduct.

PERSONAL HEALTH HISTORY FORM

Privacy notice: The primary purpose for this information is to determine medical eligibility for service.

Life in a developing nation can expose you to physical stresses and health risks unlike any previously experienced. Health and physical requirements vary greatly, depending on location. Complete *Personal Health History* and *Physical Evaluations* are mandatory for service with Sight.org and must be updated and medically reviewed at least every 2 years.

TO BE COMPLETED BY APPLICANT: (please use black ink and print clearly in English)

Name: (last/surname)				(First)	(Middle)	(Preferred)
E-Mail Address:						
Phone	Home:	Work:	Cell:	(please include country code)		
Date of birth: _____ (month/day/year)		Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Position Applied for:			Expected Duration of Service:			

Have you ever experienced or have you ever been treated for any of the following? Please check "Yes" or "No" to each question and explain any marked "Yes" below or on a separate page.

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent or severe headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Rupture or hernia? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dizzy spells, fainting, or blackouts? | <input type="checkbox"/> Yes <input type="checkbox"/> No Rectal bleeding or black stools? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or seizures? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic eye trouble or vision problems?
Date of last eye exam _____ | If you answered 'yes' to any of the questions above, please explain. If |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colonoscopy or sigmoidoscopy? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney trouble,(i.e. stones, blood, or protein in urine?) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke or chew tobacco? If yes, how |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink alcohol? If yes, how |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing trouble, i.e. frequent, recurrent cough or shortness of breath? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No TB, or exposure to TB? | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pain or pressure in your chest? | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent indigestion? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia or another blood disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems, murmur, or infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach, liver, or intestinal problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty with hearing? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice or hepatitis? | |

- Yes No Change in bowel or bladder habits?
- Yes No Urinary problems or urinary tract infection?
- Yes No Back pain or injury?
- Yes No Bone, tendon, or joint problems?
- Yes No Abnormal chest x-ray?
- Yes No Malaria, dysentery or other tropical disease?
- Yes No Frequent crying spells?
- Yes No Felt unusually depressed or sad?
- Yes No Persistent fatigue?
- Yes No Any other medical problems not already mentioned?
- Yes No Tested positive to HIV?
- Yes No Tested positive to Hep B?
- Yes No Tested positive to Hep C

PERSONAL HEALTH HISTORY FORM, continued

- Yes No Would you have a problem walking up six flights of stairs at a steady pace without stopping?
- Yes No Would you have a problem walking a distance of 3 km (approximately 1.5 miles) on a level plane at a steady pace without stopping?
- Yes No Have you ever been referred to or sought consultation or treatment from a mental health professional (counselor, psychologist, psychiatrist, pastoral, or family marriage counselor)?
- Yes No Have you ever received mental health treatment as an inpatient or as an outpatient in a day treatment center?

If you answered 'yes' to any of the questions above, please explain. If you need more space, please attach a page.

LIST ALL HOSPITALIZATIONS AND MEDICAL EVACUATIONS FOR BOTH MEDICAL AND PSYCHIATRIC ILLNESSES.

Date	Illness or Operation	Name of hospital	Location

LIST ANY CURRENT OR PAST CONGENITAL OR CHRONIC CONDITIONS.

MEDICATIONS: LIST ALL CURRENT.

Name	Amount	Frequency	How long have you been on this medication?	What are you taking it for?

ALLERGIES: List all known allergies to Food, medications, etc. and list typical reaction and treatment.

Please complete and sign below:

I, _____, have completed this form to the best of my knowledge. I also understand I need to report any changes in my health status or medical treatment received prior to my joining Sight.org, including any new medical diagnoses, surgeries, or hospitalizations. Failure to do so may result in my being sent home at my expense.

AUTHORIZATION & CONSENT FOR TREATMENT: Please Read Carefully

I request that this Personal Health History & Physical Evaluation be forwarded to the Foundations of Sight.org in Texas and I hereby consent to the transfer to the United States of all data contained in this application and any attachments thereto, including all private personal data. I also request that this Personal Health History & Physical Evaluation be forwarded to the Foundations of Sight.org location where I will be serving in order that I may be given medical attention should that become necessary or appropriate.

I certify that all statements given on this application are correct with no omissions and may result in my being sent home if health information is intentionally not disclosed.

Additionally, in the course of my service with Sight.org, if I require medical treatment while outside my country, I hereby agree to the performance of such treatment, anesthetics, and operations if, in the opinion of the present physician, it is deemed necessary.

Applicant signature

Date (month/day/year)



Immunizations

Listed below are the mandatory immunizations required prior to arrival!

Once approved for service, you will be sent a proof of immunization checklist to complete. The Immunization Checklist must be returned, no later than 4 weeks prior to your arrival.

The following are mandatory for ALL adult crew:

- **Yellow Fever:** within last 10 years (travel with documentation of yellow fever – WHO card)
- **Hepatitis B:** series of 3
- **MMR- Measles, Mumps, Rubella:** series of 2
- **TB skin test (PPD):** within 12 months of arrival
 - Result in millimeters (mm)
 - Negative or Positive? (if positive, chest x-ray required)
 - Date of Chest X-ray (within 12 months of arrival)
 - Chest X-ray report (please attach a copy)
- **Skin testing is *not* required if there is a history of a prior positive skin test (which is defined as >10mm in duration, not simply redness). However we do require a chest x-ray.**

PLEASE NOTE: TB testing is required even if you have received a previous BCG vaccine. A TB screening *blood test* can be done (Interferon-Gamma Release Assay (IGRA) such as the QuantiFERON-TB Gold or T-spot TB test) in the place of a PPD skin test. The test should be performed within 12 months of boarding the ship.

The following are mandatory for those working in Hospital, Dental and Engineering departments:

- **Typhoid:** EITHER **oral** within last 5 years OR **injection** within last 2 years
- **Hepatitis A:** series of 2
- **Tetanus/Diphtheria:** within last 10 years

The following are highly recommended for all adult crew:

- **Typhoid:** EITHER **oral** within last 5 years OR **injection** within last 2 years
- **Hepatitis A:** series of 2
- **Tetanus/Diphtheria:** booster, within last 10 years
- **Pertussis:** aka Whooping Cough
- **Polio booster:** within last 10 years
- **HIB (Haemophilus Influenza type B):** booster
- **Meningitis ACWY:** within last 5 years
- **Rabies:** series of 3

Children: Parents are required to ensure that their children are up to date with their childhood vaccinations. They should also seek advice from a Travel Clinic about additional vaccinations that the children may require before joining Sight.org. Please bring all vaccination documentation and a copy of the childhood vaccination schedule to Sight.org. Yellow Fever vaccination is a mandatory requirement for all children over 9 months of age.



PHYSICAL EVALUATION SUMMARY SHEET

IMPORTANCE OF EXAMINATION: It is important for the examiner to identify all medical conditions which will require follow-up medical care or could be adversely affected by environmental conditions, such as air pollution and poor sanitation. The consequences of not identifying pre-existing health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be assigned to a developing country where medical care is not available. All reports must be in English.

Name: _____	Exam Date: _____
Date of birth (mm/dd/year): _____ Age: _____ Height: _____ in/cm Weight: _____ lb/kg	
Blood Pressure: _____ Pulse: _____	

Areas to be examined (as appropriate)	Normal	Abnormal	Notes
Skin (record lesions, body marks, scars, etc)			
Head, Neck, Thyroid			
Ear, Nose, and Throat (comment on hearing)			
Lymph Nodes			
Eyes (include funduscopic exam, visual acuity, and color perception)			
Lungs			
Breasts			
Heart (record murmurs and abnormalities)			
Abdomen (comment on liver and spleen)			
Genitalia			
Anus, Rectum, and Prostate (if of age)			
Vascular System (record peripheral pulses and varicosities)			
Extremities and spine			
Neurological (reflexes and muscle strength recorded)			
Psychiatric			
Gynecological (note last normal exam if not examined on this occasion)			

Additional comments:

Recommendation for treatment/further follow up:

PHYSICIAN'S SIGNATURE

DATE: (month/day/year)

PHYSICIAN'S PRINTED NAME

Telephone:	
Email address:	



FRIEND REFERENCE FORM

Please fill in your name and address and give to a friend to complete.

Name of applicant: _____ (last/surname) _____ (first) _____ (middle initial)	Applicant's mailing address:
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Sight.org, an international charity, has performed eye surgical care to the poor of Togo, Africa, since 2012. Following the example of Jesus, Sight.org brings hope and compassionate service to the poor. Applicants who serve with us are often subjected to physical and emotional stresses, which should be considered in your evaluation of their personal capabilities within Sight.org.

Please visit our website at Sight.org for more information.

INSTRUCTIONS: Please be honest in your appraisal of this applicant.

1. How long and in what association have you known the applicant?
2. Please evaluate the applicant in the following areas: <input type="checkbox"/> Character: <input type="checkbox"/> Skills, abilities, strengths, and talents: <input type="checkbox"/> Emotional stability:
3. Do you have any reservations regarding this person's service with Sight.org?

Your Name (Please print):	Your Address:	
Title:		
Organization:	Tel:	Email:

To the best of my knowledge, all information shared in this reference is correct and accurate.

Signature

Date



Medical Professional REFERENCE FORM

Medical Professionals: Please fill in your name and address and give to a current professional reference who can comment on your clinical practice. If not self-employed, this should be your employer.

Name of applicant:	Applicant's mailing address:
(last/surname) (first) (middle initial)	

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Please visit our website at Sight.org for more information.

INSTRUCTIONS: Please be honest in your appraisal of this applicant

1. How long and in what association have you known the applicant?
2. Please evaluate the applicant in the following areas: <input type="checkbox"/> Character: <input type="checkbox"/> Clinical skills, abilities, strengths, and talents: <input type="checkbox"/> Relations with patients and staff: <input type="checkbox"/> Emotional stability: <input type="checkbox"/> Ability to work independently in a austere medical resource environment
3. Do you have any reservations regarding this person's service with Sight.org?

Your Name (Please print):	Your Address:	
Title:		
Organization:	Tel:	Email:

To the best of my knowledge, all information shared in this reference is correct and accurate.

_____ Signature _____ Date _____



EMPLOYER REFERENCE FORM

Please fill in your name and address and give to your current employer to complete. If you are not currently employed, please ask a former employer or mentor to complete this form and send it along with an explanation.

Name of applicant:	Applicant's mailing address:						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> <td style="border-bottom: 1px solid black; width: 33%;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">(last/surname)</td> <td style="text-align: center; font-size: small;">(first)</td> <td style="text-align: center; font-size: small;">(middle initial)</td> </tr> </table>				(last/surname)	(first)	(middle initial)	
(last/surname)	(first)	(middle initial)					

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INSTRUCTIONS: Please be honest in your appraisal of this applicant.

1. How long and in what association have you known the applicant?
2. Please evaluate the applicant in the following areas: <input type="checkbox"/> Character: <input type="checkbox"/> Skills, abilities, strengths, and talents: <input type="checkbox"/> Emotional stability:
3. Do you have any reservations regarding this person's service with Sight.org?

Your Name (Please print):	Your Address:	
Title:		
Organization:	Tel:	Email:

To the best of my knowledge, all information shared in this reference is correct and accurate.

Signature	Date
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PASTOR OR SPIRITUAL LEADER REFERENCE FORM

Please fill in your name and address and give to your Pastor or Spiritual Leader to complete. If you do not have a Pastor or Spiritual Leader, please ask a teacher, coach, or mentor to complete the form and send it in along with an explanation.

Name of applicant: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border-bottom: 1px solid black; width: 150px; text-align: center;">(last/surname)</div> <div style="border-bottom: 1px solid black; width: 80px; text-align: center;">(first)</div> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">(middle initial)</div> </div>	Applicant's mailing address:
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1. How long and in what association have you known the applicant?
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3. Do you have any reservations regarding this person's service with Sight.org?

Your Name (Please print):	Your Address:	
Title:		
Organization:	Tel:	Email:

To the best of my knowledge, all information shared in this reference is correct and accurate.

Signature	Date
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**Sight.org VOLUNTEER
AGREEMENT AND NOTICE AND PERMISSION TO BE TREATED**

You are participating in a mission project sponsored in whole or in part by Sight.org.

Please initial each line to show your agreement with the following statements.

_____ Mission projects can expose the participant to increased risks to person and property. By this agreement you are assuming the risk of harm to yourself and/or your property.

_____ In the event you and your property are harmed while participating in this project, you agree to release, discharge, and forever hold Sight.org, its directors, officers, employees, administrators, team leaders, coordinators, members and agents harmless and indemnify them, from any and all claims, demands or suits, known or unknown, fixed or contingent, liquidated or unliquidated, arising from your participation in this project.

_____ In addition, you agree that you will not institute any action or suit, in law or in equity, against Sight.org, its directors, officers, employees, administrators, team leaders, coordinators, members or agents for any harm to you or your property while participating in this project.

_____ In the event that you or your property are harmed while participating in this project, you agree to notify, in writing, the Sight.org staff of the damage and schedule an appointment, in order to discuss the matter.

_____ If discussions fail, you agree that any and all disputes or claims you feel you may have against Sight.org, its directors, officers, employees, administrators, team leaders, coordinators, members, or agents, shall be submitted to mediation prior to any further legal action. The Mediator will be mutually chosen by you and Sight.org and any fees for said mediation will be equally born by the parties.

_____ This agreement is made and performable in the State of Texas and shall be construed in accordance with the laws of the State of Texas.

_____ In the event that any portion of this agreement is determined to be unenforceable, the remaining provisions remain in full force and effect.

_____ The above provisions are binding on me, my heirs, assigns or legal representatives.

*I understand that my deposit is non-refundable and that I will be responsible for airline tickets purchased in my name upon cancellation.

*The training meetings for this mission project are critical for the spiritual unity and physical preparation of the entire team. I commit to faithfully attend all meetings at the scheduled times.

*I will refrain from using alcohol or tobacco while on the mission project.

*By signing this document I acknowledge that my photograph and/or statements may be used in any fashion, by Sight.org, in its sole discretion, including but not limited to, publications, videos and websites.

DO NOT use my photograph for future promotional materials.

Signature _____ Print Name _____ DATE: _____

FOR MINORS ONLY:

NOTE: IF VOLUNTEER NAMED ABOVE IS UNDER THE AGE OF 18, THE FOLLOWING FORM MUST BE SIGNED BY THE MINOR (Listed Above) AND BOTH PARENTS OR GUARDIANS OR, IF MARRIED MINOR, BY THEIR SPOUSE ON THE LINES BELOW.

Signature of Minor's Parent or Guardian _____

Signature of Minor's Parent or Guardian _____

If Married, Signature of Minor's Spouse _____

Criminal Background Policies

Policy for Criminal Background Screening:

All new or potential volunteers must complete an application packet which includes a Background Verification Release Form. In order to conclude the background check volunteers must include their driver's license number. Once the criminal background has been finished, Sight.org staff will evaluate the information and a decision will be made.

Background Check Offenses:

As a general rule, subject to the specific nature and severity of the offense(s), the volunteer applicant may be deemed ineligible to work or provide services to Sight.org if the volunteer is identified as having committed any of the following offenses. Sight.org reserves the right to extend considerations identified based on the seriousness and time since the offense(s):

- An offense against a minor within the past ten years.
- A sexual offense within the past ten years.
- Any matter involving a felony within the past ten years.
- A drug offense within the past five years.
- An alcohol offense within the past three years.
- Any other offense that is deemed relevant to the subject's assignment within the past five years.
- Any re-occurring matter involving any other type of criminal offense, especially if more than one occurrence of the same type of offense is alleged to have taken place within the previous eight years.

Although a disqualification is possible, a previous conviction does not automatically disqualify an applicant from consideration of volunteering with Sight.org. The Executive Director and the position supervisor will together consider the following factors in determining whether a candidate is eligible for volunteering with Sight.org.

- The relevance of the conviction to the duties and responsibilities of the position for which selected.
- The nature of the conviction(s)
- The age of the candidate when the illegal activity occurred
- The dates of the convictions
- The candidate's record since the date(s) of the conviction(s)

Disqualification from Volunteer Participation: The following rules shall apply if Sight.org learns (via criminal background search) that a prospective volunteer/host has been convicted of, has pled guilty to, has deferred adjudicative for, or has pled no contest to one of the following crimes under the laws of any State within the United States, or any other nation.

Automatic Disqualification:

- Homicide
- Crimes of rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related sexual offenses
- Crimes using weapons
- Arson
- Any violent crime, felony drug-related offense or trafficking in controlled substances
- Crimes involving child abuse, neglect, or residing on the same premises as a registered sex offender
- Crimes involving adult abuse, neglect or financial exploitation

All information supplied by potential volunteer is held in the strictest confidence and not divulged to any other staff member, board member or volunteer.



Background Verification Release Form

AGENCY INFORMATION: **PLEASE PRINT LEGIBLY**

Date	Agency Name Sight.org PO Box 8286 Tyler, TX 75711
Contact Name Beth Reed – Volunteer Coordinator	
Phone Number 903-830-2065	

APPLICANT INFORMATION:

Applicant Full Name (First, Middle, and Last)			Maiden or Other Name(s) Used	
Current Address				
City		State	Zip Code	County
Date of Birth	Driver's License Number	Exp. Date	State Issued	
Position Applied For Sight.org Volunteer				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		

I hereby authorize SIGHT.ORG and or its Service Provider to request and receive any and all background information about or concerning me, including but not limited to my Criminal History, Driving Record, and if needed other entities including my Present and Past Employers.

The criminal history, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct as committed as a juvenile. I understand that this information will be used, in part, to determine my eligibility for a volunteer position with Sight.org. I also understand that as long as I remain a volunteer here, the criminal history check may be repeated at any time. I understand that I will have an opportunity to review the criminal history as received by Sight.org and a procedure is available for clarification, if I dispute the record as received. I also understand that the criminal history could contain information presumed to be expunged.

I further release and discharge SIGHT.ORG and their Service Provider and all of their Subsidiaries, Affiliates, Officers, Employees, Contract Personnel, or Associates, from any and all claims and liability arising out of any request for information or records pursuant to this authorization and understand that it may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable.

I acknowledge that I have voluntarily provided the above information for volunteer purposes, and I have carefully read and understand this authorization.

Applicant's Signature

Date

Applicant's Printed Name

Parent/Guardian's Signature
(if under 18 years of age)

VOLUNTEER PERSONAL INFORMATION PERMISSION FORM

This is your contact information that will be used for Staff or your fellow volunteers only to contact you to substitute a shift

_____ I give permission to Sight.org Volunteer Services or Sight.org staff members to give my contact information to other Sight.org volunteers.

_____ I **DO NOT** give permission to Sight.org Volunteer Services or Sight.org staff members to give my contact information to other Sight.org volunteers.

Sight.org VOLUNTEER AGREEMENT

I agree to serve as a Sight.org volunteer and commit to the following:

1. To complete all required training for the volunteer position I accept.
2. To abide by all guidelines and procedures of Sight.org.
3. To respect the confidential nature of all records and personal contact with clients.
4. To work cooperatively with staff and other volunteers.
5. To meet time and duty commitments, or give adequate notice so that alternate arrangements can be made.

Sight.org CONFIDENTIALITY FORM ALL VOLUNTEERS

I understand that I am required to complete all training for the volunteer position I accept, to abide by all guidelines and procedures of Sight.org, to respect the confidential nature of all records and personal contact with clients, and to work cooperatively with staff and other volunteers.

Sight.org POLICY AND PROCEDURES

I have read the above and have received, read and understand the Sight.org Policy and Procedures.

Signature _____

Date _____