APPLICATION TO BECOME A CONSERVATION VOLUNTEER

Additional information is available on the DCNR web site at http://www.dcnr.state.pa.us/cons/ or at any state park/forest office. When complete, please return this form to the DCNR State Park Office or Forest District Office location that you wish to volunteer at.

STEP 1 – Complete items 1 and 2.

A. Please select one from the list below:

☐ *I would like to volunteer as an Individual (**skip STEP 2 only**):*

First name, MI, & Last name: _____ Nickname: _____

Address/City/State/Zip: _____

Phone: _____ Best time to call: _____ Email address: _____

☐ *My family would like to volunteer **(please complete STEP 2):***

Number of Family Members: _____ Contact: _____

Address/City/State/Zip: _____

Phone: _____ Best time to call: _____ Email address: _____

☐ *My Organization would like to volunteer **(please complete STEP 2):***

Organization's name: _____ Contact: _____

Address/City/State/Zip: _____

Phone: _____ Best time to call: _____ Email address: _____

B. Location, areas of interest, availability, and skills/experiences

Volunteer locations(s) – check all that apply and list the location name, park or forest name, or county name where you are interested in volunteering:

☐ State Park(s) _____

☐ State Forest (s) _____

☐ Topographic & Geologic Survey _____

☐ Other _____

Interests *(check all that apply):*

☐ Trails/Wildlife Habitat
☐ Maintenance
☐ Campground Host
☐ Snowmobile Safety Training Instructor
☐ ATV Safety Training Instructor
☐ Forest Stewardship Program
☐ Interpretation/Environmental Education
☐ Technical and Engineering
☐ Forest Fire Prevention and Protection
☐ General
☐ Research
☐ Topographic & Geologic Survey

Availability: *(check all that apply)*
☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Weekends ☐ Weekdays

Optional: List any skills, expertise, or experiences that could be pertinent to the volunteer program:

_____

STEP 2 – Complete only if volunteering as a family or a group/organization.

Organization Type:

- ☐ Individual/Family
- ☐ School/College
- ☐ Youth
- ☐ Community
- ☐ Service
- ☐ Environmental
- ☐ Business
- ☐ Religious
- ☐ Military
- ☐ Professional
- ☐ Recreational
- ☐ Other _____

List names of family members or group/organization members who will be participating in the volunteer project. Birthdates and parent/guardian signatures are required for members under the age of 18. Use additional page if additional space is required.

Name (if under 18)	Birthdate (if under 18)	Parent/guardian signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please be advised that, pursuant to Department policy, Background Checks, including PA Criminal History Record and PA Child Abuse History Clearance, are required of all adults (aged 18 years or older) who provide volunteer services to Pa DCNR under circumstances which involve any interaction with children (persons under 18 years of age) out of the presence of another adult. Clearance under this policy is a pre-requisite to Departmental approval for adult volunteer work with children in any situation where another adult is not present at all times.

☐ **I have read and agree to this statement.**
Please check the box indicating that you have read and agree to this statement.

STEP 3

Workers' Compensation Agreement

REMEMBER: It is Important to Tell Your Employer about Your Injury

The Pennsylvania Workers' Compensation Act provides wage loss and medical benefits to employees who cannot work and/or who need medical care as a result of a work-related injury. You should immediately report any injury or work-related illness to your employer. Your workers' compensation benefits could be delayed or denied if you do not notify your employer immediately.

The Commonwealth of Pennsylvania is self-insured for workers' compensation and pays all benefits through a third party claims administrator.

The commonwealth's workers' compensation third-party claims administrator is:

Inservco Insurance Services, Inc.
P.O. Box 3899
Harrisburg, PA 17105-3899
1.800.356.0438 or 717.230.8300

Your workers' compensation coordinator is located within your agency human resources office and is available to assist with any questions you have about workers' compensation. This person is:

Judy Watterson, Workers' Compensation Coordinator
Department of Conservation & Natural Resources

P.O. Box 8768
Harrisburg, PA 17105-8768
717-783-5782 or jwatterson@pa.gov
Self-Insured Bureau Code: 3000

The entity responsible for the Workers' Compensation Act is:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
717.772.4447
www.dli.state.pa.us
Auxiliary aids and services are available upon request to individuals with disabilities.

☐ By checking this box, I certify that I have received, read and understood the information provided above.

Rights and Duties Agreement

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER THE PA. WORKERS' COMPENSATION ACT SECTION 306 (f.1)(1)(i)

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

• The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.

• The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.

• The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.

• The right, during this 90-day period, to switch from one designated health care provider to another designated provider.

• The right to seek treatment from a provider if you are referred to that provider by a designated provider.

• The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.

• The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be at your expense for the applicable 90 days.

• The right to seek treatment from any health care provider after the 90-day period has ended.

• The duty to notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

Complete text of Section 306 (f.1)(1)(i)(i)

☐ By checking this box, I certify I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent that they are explained above.

STEP 4

Part I. AGREEMENT

1. **Project Description/Requirements:**

   _____

2. The organization will provide DCNR with names of its volunteers.
3. Parental or guardian consent is required for volunteers under 18 years of age.
4. The project will become the property of DCNR.
5. Volunteers are treated as employees of DCNR for purposes of automotive and general liability and workers' compensation coverage.
6. Volunteers with a valid driver's license may be permitted by DCNR to operate a Commonwealth vehicle.
7. ☐ If box is checked, the volunteer agrees to perform the job duties listed in the attached document.
8. Either party may cancel this agreement at any time.

Part II. Signatures (for families and organizations, one or more persons may sign on behalf of the group): As part of the consideration being tendered by me (or my child/ward) for being permitted to participate in DCNR outdoor recreational and educational activities in the above program on said dates: I agree (for and on behalf of myself and my child/ward) to, and do herby, waive any and all claims against, and agree to fully release, hold harmless, and indemnify, DCNR its officers, employees, agents, and volunteers from any and all claims related to any illness, injury, including loss of life, property damage, or loss of any other description which I (or my child/ward) may sustain arising out of, or in any way associated with, my (or my child/ward's) participation in this program.

Individual(s) (if 18 years or older) **or** parent/guardian (if individual is under 18):

_____ Date: _____

_____ Date: _____

Part III: DCNR Office Use

Conservation Volunteer Coordinator: _____ Date: _____

Start Date: _____ End Date: _____

Comments: