



## Contact information:

Keith Forbes  
Camp Erin, Nathan Adelson Hospice  
Camp Director  
[kforbes@nah.org](mailto:kforbes@nah.org)  
702.415.1954

Dear Prospective Volunteer,

Thank you for your interest in becoming a volunteer for Camp Erin® Nathan Adelson Hospice! Camp Erin is a weekend overnight designed for children and teens (ages 6-17) who have experienced the death of someone significant in their lives. It is a traditional, high-energy, fun-filled camp coupled with grief support and education. The camp serves approximately 30 youth and needs many volunteers to ensure its success. This year the camp is scheduled for **June 6-8, 2025** at Potosi Pines, in Las Vegas, Nevada.

There are a lot of different volunteer opportunities at Camp Erin. Enclosed you will find the Camp Erin application. We are currently looking for volunteers who want to be Cabin Leaders and Cabin Buddies as well as Day Support. Please complete and return the entire application packet which also includes the required background check authorization. On your application be sure to include any special interests, hobbies, talents, education, and training that you feel would contribute to Camp Erin.

Once the application has been received and reviewed, you will be contacted for an interview. Selections for volunteers will be based on need, availability, flexibility, interest, and experience. The majority of volunteers will be needed for the entirety of the camp program; however, some exceptions will apply. If you have questions, please do not hesitate to reach out to our team. Completed packets can be emailed to [kforbes@nah.org](mailto:kforbes@nah.org).

The time and energy commitment as a Camp Erin volunteer is high. You can count on approximately 4-6 hours of work before Camp. This includes general meetings and mandatory training. Our first Volunteer meeting is scheduled for **Saturday, February 8, 2025 at 10:00 am.**

Again, thank you for your interest and support in helping Camp Erin make a difference in the lives of children and teens who are grieving.

Sincerely,  
Keith Forbes  
Camp Director

\*Please note that all phone calls regarding Camp Erin will be returned after 4:00 pm



## Camp Erin Las Vegas Volunteer Application



---

### VOLUNTEER INFORMATION

**First and Last name:** \_\_\_\_\_

**What would you prefer to be called?** \_\_\_\_\_

*This name will appear on your name tag and does not need to be a legal name.*

**Legal name** (if different from above): \_\_\_\_\_

*This is only for our internal records and will not be viewed by anyone but the camp administrators.*

**Gender:** \_\_\_\_\_

**Pronouns:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_

**Preferred communication:**

Phone  Text  Email

**Time of day:** \_\_\_\_\_

**Mailing address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**T-shirt size:**

*(select one)*

Youth small     Youth medium     Youth large     Adult small     Adult medium

Adult large     Adult XL     Adult 2XL     Adult 3XL

**Are you an active, reserve, or National Guard military member or military veteran? If so, what branch?**

Army     Navy     Marine Corps     Air Force

Coast Guard     National Guard

## EXPERIENCE & EDUCATION

Highest level of education: \_\_\_\_\_

Please list any degrees obtained: \_\_\_\_\_

Name of Company/Employer: \_\_\_\_\_

Title/Position: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you OR your spouse currently work for New York Life Insurance Company?  Yes  No

We ask that all potential Camp Erin volunteers provide 2 references. Please provide the contact information below:

Reference #1 name: \_\_\_\_\_ Reference #1 relationship: \_\_\_\_\_

Reference #1 contact information: \_\_\_\_\_

Reference #2 name: \_\_\_\_\_ Reference #2 relationship: \_\_\_\_\_

Reference #2 contact information: \_\_\_\_\_

## VOLUNTEERING AT CAMP

What language(s) are you fluent in? \_\_\_\_\_

Have you ever volunteered with a Camp Erin?  Yes  No  
*If yes, when and which location?*

Have you ever participated in a Camp Erin as a camper?  Yes  No  
*If yes, when and which location?*

**Do you have any volunteer experience?**

*If so please provide details here*

Yes

No

---

**Have you ever been asked to relinquish any position?**

*If yes, please describe.*

Yes

No

---

**Why are you interested in volunteering at Camp Erin?** \_\_\_\_\_

---

**How did you hear about Camp Erin?** \_\_\_\_\_

---

**Which age group(s) are you MOST interested in working with? Please rank**

6-8

9-10

11-13

14-17

Wherever needed

**Are there any age group(s) are you NOT comfortable working with?**

**What special skills or interests do you have that may benefit your volunteer position at camp** *(select all that apply):*

*The below items relate to volunteer positions we have needed in the past. Please feel free to include any additional skill that you feel may benefit the Camp Erin experience.*

Technology

Movement/dance

Nurse

Photography

Singer

Handyperson

Videography

Musician

Heavy lifting

Food service

Decorating

Archery

Planning/organization

Drama/storytelling

Procurement

Games

Creative writing

Clinical support

Sports

Yoga

Certified therapy animal

Rock climbing

Arts & Crafts

Ropes course

Other

Please expand on any checked or additional skills: \_\_\_\_\_

---

---

**Which volunteer role(s) are you interested in?**

Please number your top 3 role preferences with 1 being your first choice. While we do our best to place you in your preferred role, placement is based on camper numbers and other needs of the camp program.

\_\_\_\_\_  
(#) **Cabin Big Buddy (CBB)** – This volunteer must be in attendance for the entire camp program. CBBs are responsible for the youth in their cabin, sharing supervision with other assigned CBBs. They eat meals, attend grief and recreational activities with their cabin, and provide guidance and appropriate discipline as needed – with the supervision of the Camp Erin clinical team. CBBs sleep in the same cabin with the youth campers (for overnight programs).

\_\_\_\_\_  
(Y/N) **If you are interested in this position, would you like to be a Cabin Leader?**  
This role holds the same responsibilities as above, and will also we the lead contact with camp leadership if there needs to be information relayed to/from CBBs in your cabin group. This role requires extra training.

\_\_\_\_\_  
(#) **Daytime** – This volunteer will be available during the daytime hours of a camp program to help with support, logistics, special volunteer roles, activities, etc. This volunteer will go home at the end of the day. They may volunteer 1 or more days depending on the program.

Please specify desired role: \_\_\_\_\_

**Have you had any significant deaths in your life? If so, who and when?**

---

---

---

**Volunteer training dates** (please select ONE training that you can attend):

First meeting: Saturday, February 8, 2025, at 10:00 am  
Nathan Adelson Hospice  
4131 University Center Dr. Las Vegas, NV 89119

Second Meeting:  
TBD

**For new volunteers:** After the review of your application, a team member will reach out to you to schedule a required interview that will take place prior to the training dates listed above.

## Authorization for Background Checks

I instruct and authorize NATHAN ADELSON HOSPICE (the "Company") to obtain a consumer report(s) (or background check report(s)) on me, including any investigative consumer reports and any consumer credit reports.\* I also agree that a copy of this form is valid like the signed original.

The consumer reporting agency (CRA) ADP Screening and Selection Services, Inc. (ADP SASS) will conduct the background check and prepare the background check report for the Company. ADP SASS is located at 301 Remington Street, Fort Collins, CO, 80524, and can be reached by phone at 800-367-5933, or at [www.adpselect.com](http://www.adpselect.com).

I understand that, as allowed by applicable law, the Company may rely on this authorization to order additional background check reports, including investigative consumer reports and any consumer credit reports\* (1) during my employment or time as a volunteer or independent contractor, as applicable, and (2) from any CRA other than ADP SASS without asking me for my authorization again. I understand the Company may order background check report(s) under my legal name and any other names I may have used.

I also instruct and authorize the following persons, agencies, and entities to disclose to ADP SASS and its agents all information about or concerning me, as allowed by law, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. As allowed by law, such disclosures may contain the following information pertaining to me: credit history\*; public records; a Social Security number verification; driving records; military service; credentials/certifications; worker's compensation injuries; and verification of prior employment and education.

By signing below, I understand that I am agreeing to the terms contained in this document.

If you live or work for the Company in California, Minnesota or Oklahoma: Check this box if you would like a free copy of your background check report:

Please print your full legal name:

Last Name \_\_\_\_\_

First \_\_\_\_\_

Middle \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date (Month/Day/Year)

**BACKGROUND CHECK INFORMATION**

The information requested below is collected solely for the purpose of aiding the Consumer Reporting Agency (CRA) in completing a background check on you.

\_\_\_\_\_  
First Name                      Middle Name (required)      Last Name                      Suffix

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

For Identification Purposes Only: Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

Social Security Number \_\_\_\_\_

Driver's License Number \_\_\_\_\_

State Issuing License \_\_\_\_\_

Enter Nickname(s)  
Used \_\_\_\_\_

Enter Any Other Names Used (including maiden names):

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last  
Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last  
Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last  
Name \_\_\_\_\_

Addresses Within The Past Seven Years (*use a separate sheet as needed*)

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

City/State/ZIP \_\_\_\_\_

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

Prior City/State/ZIP \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) To \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)



## Volunteer Medical Information

Please fill out everything to the best of your knowledge. Camp staff and/or a Camp Nurse may call to follow up. There will be nurses and mental health staff at camp who will provide care to volunteers as needed. The following information will be reviewed with you during check-in with the Camp Nurse at camp.

**Volunteer Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

### Emergency contact

**Name:** \_\_\_\_\_ **Phone:** \_(\_\_\_\_)\_\_\_\_\_

**Relationship:** \_\_\_\_\_

## Volunteer Medical Information

### Do you have any allergies?

*(This includes food, plant, animal/insect, environmental, medication allergies)*  Yes  No

Please list all allergies, the severity, and reaction.

---

---

**Do you use an EpiPen?** *(if so, please bring to camp)*  Yes  No

**Do you have any dietary restrictions?** *(vegetarian, gluten free, etc.)*

---

---



Date of your last Tetanus shot (DTAP or Tdap): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Tetanus boosters are recommended every 10 years. If not up to date, it is required to get a Tetanus booster prior to camp. Write "exempt" if your youth needs an Immunization Exemption form.*

**Do you have any medical concerns or considerations camp staff/nurses should know about?**

*This information is only used internally and will not be shared. We use this information to help ensure that our volunteers have the accommodations and support they need throughout the program.*

---

---

---

**Do you have any known physical, mental, or social needs which may inform your volunteer activity and/or benefit from extra consideration at camp?**       Yes       No

*(if yes, please specify)*

---

---

## **Volunteer Medications**

Staff/volunteers manage their own medications at camp. All prescription and over-the-counter medications must be stored in the designated, locked location in the Camp Nurse's station. For camper safety, no medications (over-the-counter or prescription) can be kept in the volunteer's personal belongings or on their person. Some exceptions may be approved by the camp nurse.

I agree to store all prescription and over-the-counter medications with the Camp Nurse.

Medication notes (optional): \_\_\_\_\_

---

---

I verify that the above information is complete and accurate.

Volunteer signature: \_\_\_\_\_

Volunteer name (print): \_\_\_\_\_

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