



## Prison Rape Elimination Act (PREA) Training Acknowledgement

**Level 1 (Contractors, Interns and Program Visitors who have no contact with inmates and CCAP probationers/parolees)**

By signing below, I acknowledge I was informed of my responsibilities to prevent, detect, monitor, and report all allegations and incidents of sexual abuse and sexual harassment of inmates and CCAP probationers/parolee. I further acknowledge that I received a copy of the brochure titled “A Guide to Maintaining Appropriate Boundaries with Inmates for Contractors and Volunteers of the Virginia Department of Corrections” and I have reviewed Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)*.

**Level 2 (Contractors, Interns, and Volunteers whose duties do not require contact with inmates and CCAP probationers/parolees, but the possibility for contact exists)**

By signing below, I acknowledge I have been trained on my responsibilities to prevent, detect, monitor, and report allegations and incidents of sexual abuse and sexual harassment of inmates and CCAP probationers/parolees. I further acknowledge that the brochure “A Guide to Maintaining Appropriate Boundaries with Inmates for Contractors and Volunteers of the Virginia Department of Corrections” was discussed with me and a copy was provided. Furthermore, I reviewed Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)* and Operating Procedure 135.2, *Rules of Conduct Governing Employees Relationships with Offenders* and was provided the opportunity to ask questions on the material provided.

**Level 3 (Contractors, Interns, and Volunteers whose duties require contact with inmates or CCAP probationers/parolees)**

By signing below, I acknowledge that I have been trained on my responsibilities to prevent, detect, monitor, and report allegations and incidents of sexual abuse and sexual harassment of inmates and CCAP probationers/parolees. I viewed *The Prison Rape Elimination Act (PREA) Power Point Presentation* and I was provided a copy of the brochure “A Guide to Maintaining Appropriate Boundaries with Inmates for Contractors and Volunteers of the Virginia Department of Corrections”. Furthermore, I reviewed Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)* and Operating Procedure 135.2, *Rules of Conduct Governing Employees Relationships with Offenders*. The listed Power Point Presentation, Brochure, and Operating Procedures were discussed with me and I was afforded the opportunity to ask questions on the material presented.

By my signature, I certify that I have been notified of the requirement that I must report to my supervisor or to the district/facility administration any known instances or suspicions of sexual abuse or harassment of inmates and CCAP probationers/parolees, whether in custody or on community supervision. I certify that I understand that the Virginia Department of Corrections has a zero tolerance policy for sexual abuse or sexual harassment between inmates and CCAP probationers/parolees and between staff/contractors/volunteers/interns and inmates or CCAP probationers/parolees and that I agree to abide by that policy and report any known instances or suspicions of sexual abuse or harassment of inmates and CCAP probationers/parolees.

\_\_\_\_\_  
Signature of Contractor/Volunteer/Intern/Program Visitor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of PREA Trainer

\_\_\_\_\_  
Date





### Employee Vaccination Status Form

In accordance with DHRM Interim Guidance, Ensuring a Safe Workplace, and Executive Directive Eighteen (2021):

- All state employees (whether they are in the office or teleworking) are required to provide their COVID-19 vaccination status to their Agency’s Office of Human Resources or other designated staff as noted in agency procedures.
- This Vaccination Status Form will be retained in a confidential file that is separate from the employee’s official personnel record.

Please complete the information below to disclose your current vaccination status. Failure to provide this information as required may result in disciplinary action.

<b>EMPLOYEE NAME (first, middle and last):</b>
Select the appropriate box below

<input type="checkbox"/>	<b>Fully Vaccinated</b>	<b>Date of Final Inoculation (Month/Day Year)</b>	
By selecting the box above, I am declaring that I am fully vaccinated with a COVID-19 Vaccine and presenting proof. Fully vaccinated means that it has been two weeks or more since receiving the final dose in a two-dose series or two weeks since receiving a single dose vaccination.			
<b>Certification of Vaccination Documentation as reviewed by Human Resources/Designated Staff</b>			
<b>Date of Review</b>		<b>Reviewer’s Signature/Title</b>	
<b>Type of documentation provided by the Employee (check one):</b>			
<input type="checkbox"/>	<b>Vaccination Card (hard copy or electronic-copy)</b>	<input type="checkbox"/>	<b><u>VA Health Department Document</u></b>
<input type="checkbox"/>	<b>Medical Practitioner Document</b>	<input type="checkbox"/>	<b>Other Public Health Department Document</b>

<input type="checkbox"/>	<b>Not Fully Vaccinated</b>
By selecting the box above, I am declaring that I am either partially vaccinated, or I am not vaccinated. Partially vaccinated means the individual has received only one vaccination dose in a two-dose series or that two weeks following the last inoculation has not yet lapsed.	
<b>PLEASE NOTE:</b>	
<ul style="list-style-type: none"> <li>• Regardless of the reason, employees who are not vaccinated or are partially vaccinated will be required to submit to weekly COVID-19 testing at the direction of Agency management.</li> <li>• An employee’s refusal to participate in the Agency’s COVID-19 testing plan will be considered a safety violation and may result in formal disciplinary action.</li> <li>• If fully vaccinated, employees are required to submit vaccination documentation indicating the date the vaccination was administered. Vaccination documentation includes a copy of the vaccination card or documentation acquired from your medical practitioner or public health department.</li> <li>• Employees who move to a different state agency must resubmit their vaccination status and documentation to the new employing agency. Employee vaccination status documentation will not transfer across state agencies.</li> <li>• Employees who change their vaccination status from partially- or not-vaccinated must resubmit this form along with vaccination documentation upon becoming fully vaccinated.</li> </ul>	

<b>My signature below indicates that the information provided herein is accurate and true.</b>
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**Employee Signature**

**Date**



## Receipt of Operating Procedure 135.4, Alcohol and Drug Testing

### Under the provisions of Operating Procedure 135.4, Alcohol and Drug Testing:

1. All applicants for "Safety-Sensitive" positions are subject to pre-employment drug testing for unlawful/illegal/prohibited drug use;
2. All employees working in "Safety-Sensitive" positions are subject to random drug testing.
3. All employees are subject to alcohol and drug testing when reasonable suspicion exists or following an accident or injury that meets the criteria for post-accident alcohol and drug testing.

### Please read and acknowledge by signature that you understand the following conditions:

1. If you have used an unlawful/illegal/prohibited drug, you may voluntarily inform your supervisor, Organizational Unit Head or Human Resource Officer prior to being ordered to report for random drug testing. Upon making this information known, you will be referred to an Employee Assistance Program for evaluation and treatment. After successfully completing a treatment program (as defined and confirmed in writing by the treatment care provider), you may return to work, however, you will be subject to regular drug testing for the next two years. You may voluntarily identify yourself only once during your employment with the Department of Corrections.
2. Employees are subject to alcohol and drug testing if the Department has reasonable suspicion, based on evidence, that an employee may be using unlawful/illegal/prohibited drugs or alcohol or may otherwise be impaired.
3. Employees will be required to submit to alcohol and drug testing as a result of an on-the-job accident or injury if ANY of the following occurs: a fatality, lost time, personal injury requiring immediate medical treatment outside of the unit or a recommendation by the unit's medical staff that outside treatment is necessary, non-vehicular property damage in excess of \$1,000.
4. Employees involved in an accident while driving a state vehicle or personal vehicle for state business will be required to submit to drug and alcohol testing if ANY of the following occurs as a result of the accident: a fatality; the driver is issued a citation for a moving traffic violation and there is bodily injury to a person that, as a result of that accident, requires immediate medical treatment away from the scene of the accident; the driver is issued a citation for a moving traffic violation and one or more vehicles incur disabling damage, requiring the vehicle(s) to be towed from the scene of the accident.
5. If you test positive for unlawful/illegal/prohibited drug use, your employment will be terminated. If you test positive on an alcohol test, you will be subject to disciplinary action under Operating Procedure 135.1, *Standards of Conduct*.
6. All alcohol and drug test results will remain confidential and retained in a secure location separate from other personnel files. The results will be reported to the Department's Employee Drug Testing Coordinator and the Organizational Unit Head, Human Resource Officer, or Chief of Security. Results will be disclosed within the DOC on a need-to-know basis. Results may be disclosed to other state and law enforcement agencies if deemed appropriate by the Director of Human Resources.

**Address questions concerning this operating procedure to your supervisor or Human Resource Officer.**

**I have read and understand this memorandum.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*

*Distribution: Employee and Employee's Personnel File*



**Search Fee \$10.00**

## INSTRUCTIONS

### Purpose

The Virginia Child Abuse and Neglect Central Registry is mandated by the Virginia Child Protective Law and contains the names of individuals identified as an abuser or neglector in founded child abuse and/or neglect investigations conducted in the state of Virginia. The findings are made by Child Protective Services staff in local departments of social services and are maintained by the Virginia Department of Social Services. Legal mandates for the Virginia Department of Social Services to provide a Central Registry and a mechanism for conducting searches of the registry are found in § 63.2-1515 of the Code Virginia.

### **Read all instructions before completing the form: (Incomplete forms will be returned)**

1. Answer all questions completely and accurately by printing clearly in black ink or typing your answers. Failure to complete or print clearly may delay or deny your request. Given the nature of the form and the actions to be taken when received, the **Office of Background Investigations shall not accept forms that have been altered in any fashion.** Forms that contain strike outs, correction tape or white-out will be returned.
2. If a middle name is an initial, indicate “initial only” otherwise, enter a full middle name given at birth.
3. For “other names used” list all previous names; nick names, all previous married names, legal name changes, changes due to adoption, etc. Circle appropriate title description on the form.
4. If the answer to any question is none, write “N/A”.
5. Sign the Central Registry Release of Information Form in the presence of an official Notary Public. Each request form must be notarized. Only original signatures will be accepted. No copies of the form will be accepted.
6. A \$10.00 fee is charged for each search. Payment must accompany search forms. Only money orders, company/business checks, or cashier checks will be accepted. (If multiple requests are mailed together, payment may be combined on in one money order, company/business check, or cashier’s check. (ex. 4 requests at \$10.00 each will total \$40.00). A \$50 fee will be charged for all returned checks.)

All money orders, company/business checks, or cashier checks should be made payable to:  
Virginia Department of Social Services.

#### **Personal checks and cash will not be accepted.**

7. For agencies and facilities that require several searches per year, an agency code will be assigned to expedite processing of the search requests.
8. If additional space is needed to complete the form (ie. providing information on addresses, spouses, and children) attach an 8x11 sheet sheet of paper along with your form to be mailed.
9. Search results are not transferable and are not considered official beyond the requesting agency or individual.
10. Mail your completed form and additional sheets (if used) to:

**Virginia Department of Social Services  
Office of Background Investigations - Search Unit  
801 East Main Street, 6th Floor  
Richmond, VA 23219-2901**

**Search Fee \$10.00**

**Purpose of Search, Check one:**  Adam Walsh Law  Adoptive Parent  Babysitter/Family Day Care  
 CASA  Children’s Residential Facility  Custody Evaluation  Day Care Center  Foster Parent  
 Institutional Employee  Other Employment  School Personnel  Volunteer  Other

**MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search**

Name			Payment/FIPS Code (Use only if assigned by OBI-CRU)		
Address					
City	State	Zip			
Contact Name	Tel.#	Ext			
Contact E-Mail	Mandatory if agency code has been assigned				

**PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED**

Last Name	First Name	Full Middle Name – (given at birth) - <b>No initials</b> (if middle name is an initial, indicate "Initial Only")			
Maiden Name (last name before marriage)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	Race		
Driver’s License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)			
Current Address (Include Street # and Apt #)	City	State	Zip		

**Applicant’s Prior Addresses**

Include Street # and Apt #	City	State	Zip	Start Date (MM/YY)	End Date (MM/YY)

**Marital Status** Single Married Divorced Widowed Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth (MM/DD/YYYY)
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	

**List all of your children.** If you have none, write 'N/A'. Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth (MM/DD/YYYY)
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	



**Search Fee \$10.00**

**PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION**

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

\_\_\_\_\_  
Signature of person whose name is being searched  
(Sign in presence of Notary)

\_\_\_\_\_  
Parent or Guardian signature required for minor  
children under the age of 18

**PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL**

City/County of \_\_\_\_\_  
Commonwealth/State of \_\_\_\_\_  
Acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_

\_\_\_\_\_  
**Notary Public Signature** ..... **Notary Number**  
My Commission Expires: \_\_\_\_\_

Notary Seal

**PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY**

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

2. \_\_\_\_ Based on information provided by the Local Department of Social Services, we have determined that \_\_\_\_\_ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

\_\_\_\_\_ Dept. of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

\_\_\_\_\_ Dept. of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

3. \_\_\_\_ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: \_\_\_\_\_ Date: \_\_\_\_\_

OBI Staff Only