

**ADMINISTRATIVE OFFICE OF THE COURTS
PRETRIAL SERVICES RECORDS DIVISION
100 MILLCREEK PARK
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
pretrialrecords@kycourts.net**



The process to obtain the information contained in the CourtNet Disposition System is as follows:

- Individuals** Requesting a record on yourself requires a \$10.00 fee (**check or money order**). Enclose a self addressed stamped envelope for a return reply.
- Nonprofit** Requesting a record on individuals requires a \$10.00 fee (**check or money order**) and your nonprofit number (Form #51-A-126). Your return envelope must be addressed with adequate postage, and the other envelope only needs the address of the person being checked.
- Health Care Housing Auth.**
- Licensing/ Others** A request for licensing purposes and on another person requires a \$10.00 fee (**check or money order**) and must include two envelopes. Your return envelope must be addressed with adequate postage, and the other only needs the address of the person being checked.
- Government** Government entities must provide both envelopes mentioned above, a tax exempt number for waiver of fees, contact person, phone number, and mailing address on their request. Multiple inquires can be made on a continuation form.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact Pretrial Services Records Division at (502) 573-1682 or (800) 928-6381.

PLEASE PRINT OR TYPE THE INDIVIDUALS INFORMATION CLEARLY.

SOCIAL SECURITY NUMBER: _____

NAME: _____

DATE OF BIRTH: _____

MAIDEN OR ALIAS NAMES: _____

STREET ADDRESS / P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

E-MAIL ADDRESS: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS. 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - if applicable.

_____ Individual's Signature	_____ Date
_____ Non-Profit Number (Form 51-A-126), or Tax Exempt Number	_____ E-mail address(sent to this e-mail only)
Would you like the CourtNet Records e-mailed? [] Yes [] No	
_____ Company	_____ Telephone Number
_____ Requestor/Contact Person	Please denote which purpose applies to this request: ___ Employment ___ Criminal Investigation ___ Screening Housing Applicants ___ Volunteer/Care over Juvenile ___ Licensing ___ Other (please explain) _____
_____ Address	
_____ City, State, Zip	



Louisville/Jefferson County Metro Government
Department of Community Services and Revitalization
Senior Nutrition Program

Confidentiality Policy Statement

All employees, volunteers and subcontracting agency employees of Louisville/Jefferson County Metro Government's Senior Nutrition Program shall keep confidential all information with respect to the Senior Nutrition Program as it relates to clients and potential clients which are acquired through interactions with the Metro Government Senior Nutrition Program. Confidential information is to be used solely for work-related purposes which benefit Metro Government and not for personal gain or benefit to the employee. Unless required by law, with the approval of your supervisor, no such information shall be divulged to anyone outside of the Senior Nutrition Program, including, but not limited to, family and friends, or to other employees of Metro Government who do not need to know such information to carry out their official duties. The need-to-know criteria shall be established by the Program Manager of the Senior Nutrition Program or his/her designee.

If you have any doubt about releasing any information, you should contact your supervisor for permission.

AGREEMENT

I have read the foregoing Confidentiality Policy Statement on the use of confidential information. I fully understand, in all detail, the intent and directive and hereby agree to adhere to its requirements. I further understand that violation of this agreement may result in disciplinary action up to and including termination of my employment /service with Louisville/Jefferson County Metro Government.

Employee/Volunteer

Date



seniornutrition

SENIOR NUTRITION MEALS ON WHEELS VOLUNTEER APPLICATION

APPLICANT INFORMATION			
Applicant Name		DOB	Age
Street Address			
City	State	Zip Code	
Home Phone	Work Phone	Alternate Phone	
Email		Use email as contact <input type="checkbox"/> Yes <input type="checkbox"/> No	
OCCUPATION INFORMATION			
Occupation	Working Hours	Retired <input type="checkbox"/> Yes <input type="checkbox"/> No	
VOLUNTEER AVAILABILITY INFORMATION			
Time Available To Volunteer	Days Available* M T W TH F	Do you have a car? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PERSONAL REFERENCES			
Name	Address	Phone	Zip Code
SIGNATURE			
I confirm the information on this application is accurate and complete to the best of my knowledge.			
Applicant Signature			Date

* must be available at least every other week, preferably every week

OFFICE USE ONLY			
Date Received	Training Date	KIPDA Training Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No	
# of Coolers	# of Hot Packs	# of Cold Packs	
Verified Drivers License <input type="checkbox"/> Yes <input type="checkbox"/> No		Verified Auto Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Staff Signature		Date	



**Louisville Metro Government
Agreement to Volunteer
And Accept Worker's Compensation Benefits**

Louisville/Jefferson County Metro Government ("Metro Government") and

_____ ("Volunteer") agree as follows regarding volunteering and acceptance of Workers' Compensation coverage:

- 1) Volunteer agrees to perform volunteer services as directed by Metro Government and to follow Metro policies and procedures.
- 2) Metro Government agrees to provide Workers' Compensation coverage to the Volunteer pursuant to the Kentucky Workers' Compensation Act (KRS 342, *et seq.*), for any injuries sustained during any authorized volunteer services performed on behalf of Metro Government. Metro will pay for all medical expenses incurred by Volunteer for covered injuries, with no applicable deductible or co-payments by Volunteer, in exchange for receiving voluntary services.
- 3) Volunteer accepts the coverage of the Workers' Compensation Act as the sole remedy for any damages he/she suffers from any and all services performed for the Louisville/Jefferson County Metro Government and agrees not to seek any damages not covered by the Workers Compensation Act, in exchange for being provided this free coverage.

Louisville/Jefferson County Metro Government Department: _____

Supervisor: _____

Volunteer – Signature: _____

Volunteer Name – Print: _____

Address: _____

Date: _____

For Volunteers under Age 18: Age of Volunteer: _____

If the Volunteer is under the age of 18 years, his or her parent must sign below.

Parent or Guardian Signature: _____

Parent or Guardian Name-Print: _____