



BRAIN INJURY ASSOCIATION
Since 1981 OF NEW JERSEY
EDUCATION ■ OUTREACH ■ PREVENTION ■ ADVOCACY ■ SUPPORT

June 11 - 18th 2011, Oakhurst NJ

TREK

"My favorite week of the year" TREK Participant

"I'll never forget this experience for the rest of my life" TREK Staff Member

"One of the most magic and human weeks I've ever had" TREK Staff Member

TREK is a summer respite and recreation camp program for adults funded by the N.J. Division of Developmental Disabilities. Its primary purpose is to provide respite to family members and caregivers of people with brain injury. It also allows the person with brain injury to experience a week away from the caregiver in a social and recreational atmosphere. The program is designed to serve adults, age 16 and older, with the primary diagnosis of brain injury. Planned program activities include a variety of physical, recreational, and social opportunities. Laughter is guaranteed.

THE FOLLOWING TREK POSITIONS ARE AVAILABLE:

Group Leader Responsible for organization and supervision of small groups of campers and staff. Responsible for cabin duties and camper care, and may be required to provide care for campers who require more supervision.

Nurse Responsible for supervision of medical needs of participants. Distribute medication, staff the infirmary, respond to injuries, make referrals to physicians. Review camper medical records and provide input to senior TREK staff. Assist with staff orientation and camper care.

Activity Specialist Responsible for developing a program in one of the following areas: creative arts, crafts, drama, music, yoga, nature study, sports/adaptive physical education, photography or other. Responsible for cabin duties and camper care.

Counselor Responsible for assisting TREK participants with the activities of daily living, and for participating in all activities of the TREK program. Will be responsible for camper care, including showering, toileting, dressing, grooming, feeding, transfers and social interaction.

All TREK positions are 24 hour, 7 day positions for the duration of the program. Staff training is provided.

Those who bring sunshine into the lives of others, cannot keep it from themselves.

-James M. Barrie

825 Georges Road | 2nd Floor | North Brunswick, NJ 08902
Phone 732.745.0200 | Fax 732.745.0211 | Helpline 800.669.4323 | info@bianj.org

www.bianj.org
A Chartered State Affiliate of the Brain Injury Association of America

EDWARD KIM, MD, MBA
CHAIRPERSON

BARBARA GEIGER-PARKER
PRESIDENT & CEO



Brain Injury Association of New Jersey, Inc.

825 Georges Road, Second Floor
North Brunswick, NJ 08902

Telephone:
E-Mail:
Fax

1-800-669-4323
info@bianj.org
732-745-0211

TREK 2011 APPLICATION FOR STAFF

NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ AGE: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (main) _____ (other) _____

T-shirt size _____ E-mail address _____

US CITIZEN? _____ IF NOT, GIVE VISA # AND EXPIRATION: _____

EMERGENCY CONTACT: (NAME, RELATIONSHIP, ADDRESS AND PHONE #)

DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT TREK? _____

FOR WHAT POSITION ARE YOU APPLYING? _____

ARE YOU WILLING TO WORK AS A VOLUNTEER IN THIS POSITION? _____

HAVE YOU EVER WORKED FOR BIANJ BEFORE? IF SO, GIVE DATES: _____

PRESENT EMPLOYER/SCHOOL: _____

POSITION: _____

EDUCATIONAL BACKGROUND: (INCLUDE DEGREES OBTAINED) _____

PLEASE DESCRIBE EXPERIENCE (WORK/PERSONAL) YOU HAVE HAD WITH INDIVIDUALS WHO HAVE DISABILITIES. PLEASE ALSO NOTE IF YOU HAVE EXPERIENCE WITH INDIVIDUALS WHO HAVE SUSTAINED A BRAIN INJURY OR OTHER DISABILITIES.

PLEASE LIST ANY OTHER RELEVANT EXPERIENCE OR QUALIFICATIONS.

PLEASE GIVE A BRIEF DESCRIPTION OF WHY YOU WANT TO WORK AT THIS CAMP. _____

PLEASE LIST ANY SPECIAL SKILLS, CERTIFICATION, TALENTS (I.E. CPR, FIRST AID, LIFE SAVING, GUITAR, SINGING, DANCING, ETC.).

HAVE YOU EVER PLEADED GUILTY OR BEEN FOUND GUILTY OF A CRIME? (Do not include minor traffic violations.) IF YES, PLEASE EXPLAIN. A "YES" WILL NOT NECESSARILY DISQUALIFY YOU FROM CONSIDERATION FOR EMPLOYMENT.

REFERENCES (please list three - at least one professional reference): IN ADDITION, THE ENCLOSED REFERENCE FORM MUST BE COMPLETED AND RETURNED (**waived if you are a past employee of TREK**)

(NAME) _____ (RELATIONSHIP) _____

(ADDRESS) _____ (PHONE) _____

(NAME) _____ (RELATIONSHIP) _____

(ADDRESS) _____ (PHONE) _____

(NAME) _____ (RELATIONSHIP) _____

(ADDRESS) _____ (PHONE) _____

Note: All staff will be expected to provide 24 hours, 7 day a week interaction with campers and other staff members. Please be advised that staff WILL be expected to assist with any or all activities including: showering, toileting, dressing, grooming, feeding, transfers (wheelchair, bed, toilet), mobility and social interaction. Do you understand and agree to this?

_____ If not, why not? _____

Please describe any limitations that you may have: _____

My signature will indicate that the information I have provided on this application, including information pertaining to my abilities and qualifications, is true to the best of my knowledge. I give permission to a representative of BIANJ to confirm this information.

(Signature) _____

Thank you for your interest in TREK! Please return application promptly to:

Stacy Lyons
Brain Injury Association of New Jersey
825 Georges Road, Second Floor
North Brunswick, NJ 08902



Brain Injury Association of New Jersey, Inc.

825 Georges Road, Second Floor
North Brunswick, NJ 08902

Fax 732-745-0211
Telephone: 1-800-669-4323
E-Mail: info@bianj.org

TREK Staff Reference Form

TREK Applicant: Please sign the waiver on the back of this form. Give the form to your reference and have him/her complete and return the form to the address above. Employment will not be offered without this completed reference form. (This requirement is waived if this form is on file from previous TREK employment.)

Applicant's Name _____

How well do you know the applicant? Acquaintance only _____ Fairly well _____ Very well _____

Does the applicant deal well with responsibilities and problem solving?

Rarely _____ Sometimes _____ Usually _____ Almost always _____

To the best of your knowledge, does the applicant abuse drugs or alcohol? Yes _____ No _____

Would the applicant conscientiously assume responsibility for the care of a person with a disability?

Might not _____ Sometimes _____ Usually _____ Don't know _____ Constantly _____

Would you be happy to have this person as your son or daughter's counselor? Yes _____ No _____

Please rate the applicant from 1 to 10 in the following areas:

1- strongly disagree 10-strongly agree

In my experience with the applicant, I feel that he/she is:	1-10
Willing to cooperate with others	
Alert and shows good judgment	
Able to see tasks through to completion	
Neat in personal appearance	
A self starter and shows initiative	
Caring and patient with others	
Able to follow instructions and procedures	
Able to get along with peers	
Able to accept guidance	
Tactful in relation to the feelings of others	
Dependable	
Accepting of others' differences	

(Continues on other side)

Additional Comments: _____

Name of person filling out reference form _____

Address _____

Phone _____ Work/Other Phone _____

Employer _____

Relationship to applicant _____ Years known _____

Signature _____ Date _____

Thank you for taking the time to evaluate this individual. Your insights are highly respected and will be noted. Thank you also for your prompt return of this form, as our applicant cannot be processed further without your response. Please return this reference form directly to the address listed below.

**Stacy Lyons, TREK Coordinator
Brain Injury Association of New Jersey
825 Georges Road, Second Floor
North Brunswick, NJ 08902**

Fax: 732-745-0211



WAIVER

I, the undersigned applicant, do waive my right of review of this recommendation. I understand that the contents are confidential and will not be available to me now or in the future.

Applicant's signature _____ Date _____