VOLUNTEER ENROLLMENT APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone / Cell Phone

Email: _____ Emergency Contact Telephone Number

What type of volunteer position are you interested in? _____

List any professional license, registration, or certificate you currently possess (include certificate/license number): _____

List any special skills, interests, or hobbies: _____

List any special considerations or needs: _____

List two personal references not related to you whom you have known for more than one year:

NAME
ADDRESS
CITY/STATE ZIP
PHONE

NAME
ADDRESS
CITY/STATE ZIP
PHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

Specify the days and time frames you are available to volunteer: _____

Day of Week	Hours	Day of Week	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?
Yes _____ No _____ If answer is yes, please explain (including types of offenses and dates):

_____

It shall be a misdemeanor of the first degree to fail to disclose, by false statement, misrepresentation, impersonations or other fraudulent means, any material fact used in making a determination as to a person's qualifications to work as a volunteer.

I understand that, to protect persons served by the department, a routine check through law enforcement, license bureaus, agency files, and references may be made. I understand that a criminal offense will not automatically exclude me from all volunteer positions; however, certain convictions will exclude me from volunteering in some positions. I understand that if I answered no to the criminal offense question on the front of this application and a record should be obtained, it will prevent me from volunteering for the department regardless of the offense. I understand upon submission of this application it becomes public record.

I understand and agree that all information as it relates to persons served by the department is to be held confidential in compliance with Florida Statutes. All information that should come to my attention and knowledge as privileged and confidential will not be disclosed to anyone other than authorized personnel and that I shall conduct myself in accordance with the departmental security policies. I understand that failure to comply may result in criminal prosecution.

I affirm that all information on this application is true and correct.

_____ _____/_____/_____

Signature Date

INTERVIEWER'S COMMENTS
(For Agency Use Only)

Date of Interview: ___/___/_____ **Interviewer's Name:** _____

_____

_____

_____

_____

Screening Required: Yes _____ **No** _____ **Date Screening Completed:** _____

Date Orientation Completed: _____

WORK ASSIGNMENT
(For Agency Use Only)

_____ _____

Program **Location**

_____ _____

Supervisor **Date of Placement**

It is unlawful for an employer to refuse or deprive any individual of volunteer opportunities because of race, color, religion, sex, national origin, age, marital status, or handicap. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, 2009 Apalachee Parkway, Suite 100, Tallahassee, Florida 32301-4857.

Florida HEALTH

VOLUNTEER RECORD CHECK

I, _____, hereby grant
Print Full Name: First Middle Last (Maiden, if applicable)

permission to the Department of Health to obtain information from local and state law enforcement agencies to help determine my suitability to serve as a Department of Health volunteer. I understand that if the records check shows any violations committed or other information about my background that would indicate unsuitability or a risk, I may not be accepted into the Department of Health Volunteer Program.

_____ _____
Social Security Number Date of Birth

_____
Race/Sex

_____
Complete Address City State Zip

_____ _____
Signature Date

VOLUNTEER PERSONAL REFERENCE QUESTIONNAIRE

Name of Volunteer/Intern Applicant _____ Date Completed _____

As required by section 110.503, Florida Statutes and section 60L-33.006, Florida Administrative Code, reference checks must be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Department of Health. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

1. How long have you known the volunteer applicant? _____
2. To your knowledge, has the applicant ever been convicted of a crime? _____
3. Do you consider him/her to be of good moral character? If no, please explain. _____
   _____
4. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____
   _____
5. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____
6. Do you have any additional comments concerning the applicant's character or reliability? _____
   _____
7. What is your relationship to the applicant? _____

_____ Reference Signature

_____ Name (please print)

_____ Address

_____ Telephone

_____ City State Zip

Thank you for your time.

Upon completion, please return this form to:

Joan O. Rivera
Public Health Preparedness Coordinator and
MRC Coordinator
Florida Department of Health in St. Lucie County
5150 NW Milner Drive
Port St. Lucie FL 34983

PERMISSION AND RELEASE

I give permission to the Florida Department of Health (DOH) to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, and/or take photographs of the appearance of (please print name of subject) _____Age (if minor child) _____, and to release these images to the news media, use for posting on the DOH's Intranet or Internet, use in internal or external publications, or use in any other manner deemed appropriate by DOH employees to publicize the DOH, its programs and activities, its employees, or to otherwise fulfill the mission of the DOH.

I acknowledge that the DOH is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. The video and/or photographs may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

The DOH has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold the DOH, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

_____ _____
Signature of subject, parent Or legal guardian age if minor) Witness (print name)

_____ _____
Relation to above named age Witness Signature

_____
Address of subject, parent, or legal guardian

_____ _____
City, State, Postal Code Date

_____
Telephone Number

☐ I am revoking this consent for use on the Internet or intranet Date: _____

I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold the Department of Health responsible for instances of these violations. The Department of Health agrees to remove from the site as many copies of the item as possible; however, if a copy is located within the site after the fact, I may provide the written URL, address, location, or other appropriate information to have it removed.

Signature:_____
(Signature of Parent or Legal Guardian required, if subject is younger than 18 years old.)

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FAX: 850/488-6495

www.FloridasHealth.com
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FACEBOOK:FLDepartmentofHealth
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