To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis Governor

Joseph A. Ladapo, MD, PhD

State Surgeon General

Vision: To be the Healthiest State in the Nation

VOLUNTEER ENROLLMENT APPLICATION

Name	(Last)	(First)		(1	Middle)
Mailing Add	dress	City		- 10.11	Zip
Work Telep	hone	/ Home Telephone	/ Cell F	hone	
			30		
		E	Emergency Contact	Telephon	e Number
What type	e of volunteer	position are you intereste	d in?		
		ense, registration, or cert			ss (include
List any s	special skills, i	nterests, or hobbies:			
List any s	special conside	erations or needs:			
List your	most recent ve	olunteer or employment e	xperience:		
EMPLOYEI	R	COMPLETE MAILING AE	DDRESS	Т	ELEPHONE
JOB TITLE			DATES OF VOL	.UNTEER/E	MPLOYMENT

Florida Department of Health Volusia County Health Department Office of Community Health

1845 Holsonback Dr. • Daytona Beach, FL 32117 PHONE: 386-281-6472 • FAX: 386-274-0879

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	_			
Specify the days and tin	ne frames you are a	vailable 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		/ 		



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	INTERVIEWER'S COMMENTS (For Agency Use Only)			
Date of Interview:/_/	Interviewer's Name:			
	Date Screening Completed:			
	ORK ASSIGNMENT r Agency Use Only)			
Program	Location			
Supervisor	Date of Placement			
	dual of volunteer opportunities because of race, color, religion, sex, national origin, by have been discriminated against may file a complaint with the Florida			
	Please return completed form via US mail, fax or email to:			
	Taravn Korkus-Nix			

Tarayn.Korkus-Nix@flhealth.gov

1845 Holsonback Dr.

Fax: 386-274-0879

Daytona Beach, FL 32117



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VOLUNTEER APPLICATION MISSION, VISION, AND VALUES

Mission

to the health of all people in Florida through integrated state, county, and

community efforts.			
Vision			
To be the Healthiest	State in the Nation.		
Values (ICARE)			
nnovation:	We search for creative solutions and manage wisely.		
Collaboration:	We use teamwork to achieve common goals & solve problems.		
Accountability:	We perform with integrity & respect.		
Responsiveness:	We achieve our mission by serving our customers & engaging our partners.		
Excellence:	We promote quality outcomes through learning & continuous performance improvement.		
I have read and unde	erstand the above items.		
Signature	Date		



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VOLUNTEER APPLICATION CONFIDENTIALITY FORM

The purpose of this "Memorandum of Understanding" is to emphasize that all information held in health records is confidential, with access governed by state and federal laws. Information which is confidential includes the client's name, address, medical, social and financial data and services received. Data collection by setting which protects the client from unauthorized individuals. Information discussed by health team members at conferences of team meetings must be held in strict confidence. Client health information should not be discussed outside the agency.

Chapter 384.29, F.S., addresses the need for special discretion in handling of sexually transmitted disease information. Sexually transmitted diseases, by their nature, involve sensitive issues of privacy and all programs designed to deal with these diseases should afford clients privacy, confidentiality and dignity.

I have read Chapter	384.29, F.S.	I understand a	and agree to	abide by the	provision of	of this
memorandum.						

Signature	Date



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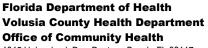
Joseph A. Ladapo, MD, PhD

State Surgeon General

VOLUNTEER PERSONAL REFERENCE QUESTIONNAIRE

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_ Na	me of Volunteer/Intern Applicant	Date Completed		
ref vo	erence checks must be completed for the above	lealth. Your name has been given as a personal		
1.	How long have you known the volunteer applica	ant?		
2.	To your knowledge, has the applicant ever bee	n 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			





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VOLUNTEER PERSONAL REFERENCE QUESTIONNAIRE

Na	me of Volunteer/Intern Applicant	Date Completed			
refe vol	required by section 110.503, Florida Statutes and secerence checks must be completed for the above applicanteer services to clients of the Department of Health. erence, and we would appreciate your comments on the	cant. This applicant wishes to provide Your name has been given as a personal			
4.	How long have you known the volunteer applicant?				
5.	To your knowledge, has the applicant ever been conv	ricted of a crime?			
6.	Do you consider him/her to be of good moral character	er? If no, please explain.			
8.	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:				
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