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 your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

Florida Department of Health
Volusia County Health Department
Office of Community Health
717 W. Canal St. • New Smyrna Beach, FL 32168
PHONE: 386-663-6825 • FAX: 386-274-0879
FloridaHealth.gov

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 Park

Please return completed form via US mail, fax or email to:

Tarayn Korkus-Nix

717 W. Canal St.

New Smyrna Beach , FL 32168

Fax: 386-274-0879

Tarayn.Korkus-Nix@flhealth.gov

VOLUNTEER APPLICATION

MISSION, VISION, AND VALUES

Mission

To protect, promote and improve 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)

Innovation: 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 understand the above items.

Signature _____ Date _____

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 and agree to abide by the provision of this memorandum.

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

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_____

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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9. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____

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_____ _____
Reference Signature Name (please print)

_____ _____
Address Telephone

_____
City State Zip