FLORIDA DEPARTMENT OF HEALTH

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): _____

FLORIDA DEPARTMENT OF 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

Exhibit J

FLORIDA DEPARTMENT OF HEALTH

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: _____

Exhibit E

FLORIDA DEPARTMENT OF HEALTH

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: _____

Exhibit E

VOLUNTEER CODE OF ETHICS

I hereby acknowledge that I have received, read, understand, and will adhere to the Florida Department of Health Code of Ethics Storyboard.

_____ _____

Signature of Volunteer Date

_____

Printed Name

Acceptance & Acknowledgement

I hereby acknowledge that I have received, read, understand, and will adhere to the Florida Department of Health Information Security and Privacy Awareness Policy.

_____ _____

Signature Date

_____

Printed Name