



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

 NAME

 ADDRESS

 ADDRESS

 CITY/STATE ZIPCODE

 CITY/STATE ZIPCODE

 PHONE

 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



VOLUNTEER SERVICES RECORDS CHECK

I, _____, hereby grant permission to
Print Full Name: First Middle Last (Maiden, if applicable)
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 risk, I may not be accepted into the Department of Health Volunteer Program

Social Security Number

Date of Birth

Sex: Male Female

Race: (Check Only One)

White Black Hispanic Asian or Pacific Islander

Native American _____ Other (Specify)

Complete Address

City

State

Signature

Date

The Palm Beach County Health Department
Promoting, protecting and improving the health and safety of all people in Palm Beach County

VOLUNTEER OPPORTUNITY REGISTRATION

Name: _____

OPPORTUNITY CATEGORIES

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> CHILDREN | <input type="checkbox"/> DISASTER/
EMERGENCY | <input type="checkbox"/> TRANSLATORS |
| <input type="checkbox"/> TEENS | <input type="checkbox"/> HEALTH EDUCATION | <input type="checkbox"/> FAMILIES |
| <input type="checkbox"/> ADULT | <input type="checkbox"/> HEALTH CLINIC | <input type="checkbox"/> ADMINISTRATION |
| <input type="checkbox"/> ELDERLY | <input type="checkbox"/> COMPUTER/
SOFTWARE | <input type="checkbox"/> COMMUNITY
DEVELOPMENT |
| <input type="checkbox"/> ENVIRONMENT | | <input type="checkbox"/> OTHER |

SCHEDULE

- | | |
|-------------------------------------|---|
| WEEKDAYS | <input type="checkbox"/> YEAR ROUND |
| <input type="checkbox"/> MORNINGS | <input type="checkbox"/> SEASONAL |
| <input type="checkbox"/> AFTERNOONS | <input type="checkbox"/> SPECIAL EVENTS |

YOUR AGE GROUP

- | |
|--|
| <input type="checkbox"/> TEEN (14-17) |
| <input type="checkbox"/> YOUNG ADULT (18-24) |
| <input type="checkbox"/> ADULT (25-54) |
| <input type="checkbox"/> SENIOR (55+) |

LOCATION DESIRED

- | | |
|---|---|
| <input type="checkbox"/> SOUTH COUNTY | <input type="checkbox"/> NORTH COUNTY |
| <input type="checkbox"/> CENTRAL COUNTY | <input type="checkbox"/> WESTERN COUNTY |

SKILLS BANK (Skills you possess)

CLERICAL/OFFICE

MICROSOFT OFFICE

- WORD
- EXCEL
- POWERPOINT
- ACCESS
- CLERICAL
- PARALEGAL
- TYPING
- WORD PROCESSING
- WEB DESIGN
- MAILINGS
- DATA ENTRY
- FILING
- RECEPTIONIST
- STAFF ASSISTANT

COMMUNICATIONS

- EDITING
- WRITING
- PROPOSAL/TECH.
WRITING
- PUBLIC SPEAKING AS
A REPRESENTATIVE ON
HEALTH ISSUES
- SPECIAL EVENTS
- ART & GRAPHICS
- CUSTOMER SVS.

HUMAN SERVICES

- PEER PROGRAMS
- PARENTING SKILLS

SECOND LANGUAGES

- SPANISH
- CREOLE
- FRENCH
- SIGN LANGUAGE
- OTHER _____

EMERGENCY/DISASTER

- RESPONSE
TEAM (HURRICANE)
- EPIDEMICS

CRAFTS

- ARTS & CRAFTS
- SEWING
- KNITTING

OTHER

AREAS OF INTEREST

HEALTH CLINIC

- SCHOOL HEALTH
- PATIENT NAVIGATOR
- MATERNITY
- BREASTFEEDING EDUCATION
- PEDIATRICS
- FAMILY PLANNING
- IMMUNIZATIONS
- NUTRITION/WIC
- ADULT MEDICAL
- HIV/AIDS ISSUES
- NURSING
- DOCTORS
- DENTAL
- TUBERCULOSIS
- SEXUALLY TRANSMITTED DISEASES
- VITAL STATISTICS
- MEDICAL RECORDS
- FRONT DESK/RECEPTION

ADMINISTRATION

- ACCOUNTING/BUDGET SERVICES
- BOARD MEMBERSHIP/AUXILIARY
- FUNDRAISING
- SPECIAL EVENT FUNDRAISING
- GRANT WRITING
- LEGAL ISSUES
- MARKETING/PUBLIC RELATIONS
- PROJECT COORDINATION
- PERSONNEL ASSISTANCE
- CLOTHING & FOOD BANK
- ENVIRONMENTAL 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? **(MAY NOT BE A RELATIVE)**

Reference Signature

Name (please print)

Address

Telephone

City

State

Zip

**Upon completion, please return this form to your area Volunteer Coordinator



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