



**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 ZIP	CITY/STATE ZIP
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 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: \_\_\_\_\_



**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:

- 4. How long have you known the volunteer applicant? \_\_\_\_\_
- 5. To your knowledge, has the applicant ever been convicted of a crime? \_\_\_\_\_
- 6. Do you consider him/her to be of good moral character? 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: \_\_\_\_\_  
\_\_\_\_\_
- 9. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? \_\_\_\_\_
- 10. Do you have any additional comments concerning the applicant's character or reliability?  
\_\_\_\_\_
- 11. 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: \_\_\_\_\_



## Volunteer Health Services Code of Ethics

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Volunteers are subject to a Code of Ethics similar to that of paid employees. The department expects volunteers to complete their assigned tasks and to be accountable for the quantity and quality of their work.

Volunteers should make a firm commitment of their time, talents and skills during a defined period. If volunteers cannot meet this commitment on occasion, they are to notify their supervisor and/or client(s) in a timely manner.

Volunteers will conduct themselves in a professional manner, treating others with dignity and courtesy at all times.

Volunteers will keep confidential all information they may learn directly or indirectly about a client or co-worker. Volunteers will only seek information on a client that is necessary in the performance of an assigned task.

Volunteers will share their work related problems, criticisms or suggestions only with their supervisor or the volunteer service center specialist, as appropriate.

Volunteers will maintain an attitude of open-mindedness and a willingness to accept training and supervision. They will follow standard department policies and procedures.

Each person, whether paid staff or unpaid volunteer, brings unique gifts to the department. Volunteers enrich the department and the lives of our clients.

Volunteers will attend conferences and meetings as directed by their supervisors. They will maintain accurate records and report their volunteer time as directed.

I have read this code of ethics and agree to abide by it.

\_\_\_\_\_  
Volunteer Name/Signature

\_\_\_\_\_  
Volunteer Coordinator



**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