



**VOLUNTEER SERVICES APPLICATION**

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone Emergency Contact Person Telephone

Group name and leader (If Applicable):

List any professional or occupational registration, license, or certificate you or your group hold (include certificate/license numbers):

List any special skills, interests, or hobbies:

List two references not related to you whom you have known for more than one year:

NAME COMPLETE MAILING ADDRESS TELEPHONE

NAME COMPLETE MAILING ADDRESS TELEPHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

Circle the days you are available to volunteer: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Specify the hours you are available to volunteer: From: To:

Are you able and willing to transport patients using your vehicle? Yes No

Are you able and willing to transport patients in a state vehicle? Yes No

If yes, please provide your driver's license number and insurance carrier:

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 that applications submitted for state volunteer services are public records.

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is a new applicant: \_\_\_\_\_ an update: \_\_\_\_\_

Type of Volunteer: \_\_\_\_\_ Individual \_\_\_\_\_ Group \_\_\_\_\_ Intern/Practicum  
\_\_\_\_\_ Community Services \_\_\_\_\_ Other (specify)

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, 325 John Knox Road, Building F, Suite 240, Tallahassee, Florida 32399-1570.



**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

\_\_\_\_\_  
Complete Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
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

Thank you for your time.

Upon completion, please return this form to

Sonji L. Hawkins, MRC Coordinator  
 St. Lucie County Health Department  
 5150 NW Milner Drive  
 Port St. Lucie FL 34983



