Dear Volunteer:

Thank you for your interest in the Florida Department of Health in Pinellas County’s Volunteer Services Program.

Attached is a volunteer packet. Please fill it out and return to Volunteer Services Program by mail, fax or bring to the office at the following address:

Volunteer Services Program  
Florida Department of Health in Pinellas  
Tammy Pruitt  
8751 Ulmerton Rd. Largo, Fl. 33771  
Phone: 727-820-4125  
Fax: 727-507-4333

**Personal References**

Two personal references from two individuals not related to you are required. For your convenience, there are two reference forms in the packet.

**Licensed Health care Professionals**

Please include a copy of your medical license.

When I receive your completed packet, you will be contacted. Thank you for wanting to make a difference in Pinellas County.

If you have any questions or need assistance with the forms, please feel free to contact Volunteer Services at 727-820-4125.

Sincerely,

Tammy Pruitt  
Volunteer Services Program Coordinator
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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>ADDRESS</td>
</tr>
<tr>
<td>CITY/STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>CITY/STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>PHONE</td>
<td>PHONE</td>
</tr>
</tbody>
</table>

List your most recent volunteer or employment experience:

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>COMPLETE MAILING ADDRESS</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOB TITLE</td>
<td>DATES OF VOLUNTEER/EMPLOYMENT</td>
<td></td>
</tr>
</tbody>
</table>

Specify the days and time frames you are available to volunteer:

<table>
<thead>
<tr>
<th>Day of Week</th>
<th>Hours</th>
<th>Day of Week</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
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<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
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</table>

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 Parkway, Suite 100, Tallahassee, Florida 32301-4857.

DH 1474, 07/13
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)

Volunteer Health Services 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 Coordinator
Volunteer Personal Reference Questionnaire

Name of Volunteer 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: The Volunteer Coordinator in your application packet.
VOLUNTEER RECORD CHECK

I, hereby grant 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 __________________________