



## 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

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

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/<br>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/<br>SOFTWARE  | <input type="checkbox"/> COMMUNITY<br>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



**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