

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

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

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			

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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

OR

Click to send this form via email.

Print & Mail

Mail To:

Attention Harriet Simmons
Florida Department of Health Walton County
362 State Highway 83
Defuniak Springs, FL 32433

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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 _____