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**

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 disability. 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.

FLORIDA DEPARTMENT of HEALTH in DUVAL COUNTY

STUDENT TRACKING FORM

All students receiving clinical experience via the Florida Department of Health in Duval County as a documented course of study must complete this form.

Date: _____

Name: _____

Emergency Contact/Telephone Number: _____

Name
School/University _____

Area of Study: _____

Clinical Rotation: _____

Professional License Number (if applicable): _____

☐ Resident	☐ Pharmacy	☐ Dental Hygiene	☐ Public Health
☐ Physician Asst	☐ Nutrition/Dietetic	☐ Dental Asst	☐ Business Off
☐ NP	☐ Counselor	☐ Comp Tech	☐ Health Admin
☐ RN/BSN	☐ Medical Asst	☐ Billing & Coding	☐ LPN
☐ Other _____			

Name of Health Center, Program or Department: _____

Start Date: _____ Ending Date: _____

Total Hours Required : _____ Hours per Day: _____ Hours per week: _____

Volunteer Service Leave and Attendance Policy

You are vital to the Department of Health. You are integral part of the agency and assist in expanding our resources to improve the quality of life and health of the residents of Florida.

The Volunteer Service Program works with numerous schools, colleges, and universities to utilize students, interns and residents to provide clinical, field or practical experience. Our staff is committed to providing only superior care and services to our clients. As part of our team, we expect your commitment to the same type of superlative care and service.

Your transition into a volunteer position with the Health Department can be easy when you become familiar with the Department's mandatory policies and procedures. Pertinent policies and procedures are located in the Volunteer Handbook. The Volunteer Coordinator will review the handbook with you.

Volunteers who expect to be absent or late from work for any reason must notify the Health Department supervisor or Volunteer Coordinator. They must indicate the date and time they expect to return to work. This will allow suitable work arrangements to be made and avoid undue hardship on clients and fellow employees and volunteers. Unexcused absentee(s) may result in a review by the Health Department Supervisor and Volunteer Coordinator.

I agree and will comply with the leave policy while volunteering in the Duval County Health Department.

Signature: _____ Date: _____

VOLUNTEER FINGERPRINT REQUEST FORM

ORIGINATING OFFICE INFORMATION:

OFFICE USE ONLY
DATE: _____ OFFICE CONTACT: _____
OFFICE ACRONYM: _____ TELEPHONE NUMBER: _____

EMPLOYEE INFORMATION:

NAME: _____

DATE OF BIRTH: _____

CURRENT ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PLACE OF BIRTH: _____

U.S. CITIZEN: ☐ YES ☐ NO IF NO, WHAT COUNTRY: _____

SEX: _____ RACE: _____

EYE COLOR: _____ HAIR COLOR: _____ HEIGHT: _____ WEIGHT: _____

Do you have a relative working for the agency: ☐ YES ☐ NO

If yes, name of relative: _____

EMPLOYEE INFORMATION:

POSITION TITLE: _____

LOCATION: _____

PRECEPTOR: _____

Please send this form to your servicing HR office as soon as possible:

Human Resource Division
Florida Department of Health-Duval
900 University Boulevard, North
Jacksonville, Florida 32211

BACKGROUND SCREENING CONSENT AND STATEMENT FORM

I hereby authorize The Florida Department of Health to submit a set of my fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I further authorize the Department to sign FieldPrint's "eConsent Waiver" on my behalf, if I am fingerprinted at a FieldPrint location. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the Federal Bureau of Investigation (FBI). Pursuant to Title 28, Code of Federal Regulations (CFR), Sections 16.30-16.34 and that I could then freely disclose any such information to whomever I chose.

I understand that, my fingerprints may be retained at FDLE and the FBI for the purpose of providing any subsequent arrest notifications, upon request you may provide me a copy of the criminal history record report if any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I am aware that procedures for obtaining a change, correction, or updating of the FDLE or FBI criminal history are set forth in F.S. 943.056 and Title 28, CFR, Section 16.34. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

I understand that my position has been designated as "sensitive" due to the trust and responsibility required, and that background screening is a condition of employment. This consent applies to any future screenings and/or rescreening conducted by the Department.

I understand that an arrest or conviction for a disqualifying criminal offense described in Section 435.04, F.S., may lead to a disqualification of employment, unless an exemption is granted by the Department. Additionally, I understand that if I am arrested or convicted of any criminal offense while working with the Department (including, but not limited to, those described in Section 435.04,F.S.), I will notify my supervisor within two (2) business days.

_____ _____

Applicant Signature Date Signed

_____

Printed Name

cc: Personnel File

Revised 06/28/2020

DISCLOSURE OF SOCIAL SECURITY NUMBER

In order to complete the employment process, you are required to provide your social security number pursuant to Section 119.071(5)(a)2, Florida Statutes, to the Department of Health (DOH). You will also be required to provide a copy of your social security card.

Providing your social security number to the department will minimize administrative delays associated with the employment process.

Your Social Security number is used by the department for payroll and benefits purposes; for verification and tracking of employment and financial history, military service, education, training, and certifications; to facilitate required criminal background checks and investigations; and, if your position requires you to be drug tested, for drug testing purposes. The department will not disclose your social security number to anyone outside of the department except for the purposes mentioned in this disclosure or as otherwise required by law.

I acknowledge receipt of this disclosure statement.

Date: _____

Employee Name: _____

Employee Signature: _____

Employee People First ID Number: _____

Social Security Number: _____

Date of Birth: _____

ORIGINAL TO PERSONNEL FILE

COPY TO EMPLOYEE