



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 ADDRESS CITY/STATE ZIP 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:

Table with 4 columns: Day of Week, Hours, Day of Week, Hours. Rows include Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday.

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



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): _____

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Resident | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Dental Hygiene | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Physician Asst | <input type="checkbox"/> Nutrition/Dietetic | <input type="checkbox"/> Dental Asst | <input type="checkbox"/> Business Off |
| <input type="checkbox"/> NP | <input type="checkbox"/> Counselor | <input type="checkbox"/> Comp Tech | <input type="checkbox"/> Health Admin |
| <input type="checkbox"/> RN/BSN | <input type="checkbox"/> Medical Asst | <input type="checkbox"/> Billing & Coding | <input type="checkbox"/> LPN |
| <input type="checkbox"/> 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: _____