Light of the World Clinic, Inc.
806 E. Prospect Road
Oakland Park, FL 33334
www.FlaFreeClinic.org

VOLUNTEER SERVICES APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone   Emergency Contact Person / Telephone

Group name and leader (If Applicable): ______

List any professional or occupational registration, license, or certificate you or your group hold (include certificate/license numbers): ______

List any special skills, interests, or hobbies: ______

List two references not related to you whom you have known for more than one year:

NAME COMPLETE MAILING ADDRESS TELEPHONE

NAME COMPLETE MAILING ADDRESS TELEPHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

Circle the days you are available to volunteer: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Specify the hours you are available to volunteer: From: ______ To: ______

Are you able and willing to transport patients using your vehicle? Yes ____ No ____
Are you able and willing to transport patients in a state vehicle? Yes ____ No ____
If yes, please provide your driver's license number and insurance carrier: ______

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):

DH 1474, 12/97

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 that applications submitted for state volunteer services are public records.

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:** ______________

____

____

____

____

____

This is a new applicant: ______ **an update:** ______

Type of Volunteer: ______ **Individual** ______ **Group** ______ **Intern/Practicum**

______ **Community Services** ______ **Other (specify)**

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.

DH 1474, 12/97

VOLUNTEER SERVICES
AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida County of ____________________

Before me this day personally appeared ____________________ who, being duly sworn, deposes and says:

I am an applicant for volunteerism with Broward County Health Department
____

By signing this form, I am swearing that I have not been found guilty or entered a plea of guilty or nolo contendere (no contest), regardless of the adjudication, to any of the following charges under the provisions of the Florida Statutes or under any similar statute of another jurisdiction. I also attest that I do not have a delinquency record that is similar to any of these offenses.

I understand I must acknowledge the existence of any criminal records relating to the following list regardless of whether or not those records have been sealed or expunged. I understand that I am also obligated to notify my supervisor of any possible disqualifying offenses that may occur while volunteering in a position subject to background screening under Chapter 435, Florida Statutes.

Sections:	415.111	adult abuse, neglect, or exploitation of aged persons or disabled adults
	741.28	domestic violence
	782.04	murder
	782.07	manslaughter
	782.071	vehicular homicide
	782.09	killing of an unborn child by injury to the mother
	784.011	assault, if the victim of the offense was a minor
	784.021	aggravated assault
	784.03	battery, if the victim of the offense was a minor
	784.045	aggravated battery
	787.01	kidnapping
	787.02	false imprisonment
	794.011	sexual battery
	794.041	prohibited acts of persons in familial or custodial authority
Chapter:	796	prostitution
Section:	798.02	lewd and lascivious behavior
Chapter:	800	lewdness and indecent exposure
Section:	806.01	arson
Chapter:	812	felony theft and/or robbery
Sections:	817.563	fraudulent sale of controlled substances, if the offense was a felony
	825.102	abuse, aggravated abuse, or neglect of disabled adults or elderly persons
	825.1025	lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
	825.103	exploitation of disabled adults or elderly persons, if the offense was a felony
	826.04	incest
	827.03	child abuse, aggravated child abuse, or neglect of a child
	827.04	contributing to the delinquency or dependency of a child
	827.05	negligent treatment of children
	827.071	sexual performance by a child
Chapters:	847	obscene literature
	893	drug abuse prevention and control only if the offense was a felony or if any other person involved in the offense was a minor

-- COMPLETE OTHER SIDE --

ONE OF THE FOLLOWING STATEMENTS MUST BE MADE:

Under the penalty of perjury, which is a first degree misdemeanor, punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to ss. 837.012, or 775.082, or 775.083, Florida Statutes, I attest that I have read the foregoing, and I am eligible to meet the standards of good character for this caretaker position.

____
Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

____
Signature of Affiant

OR

for teachers and non-instructional personnel in lieu of fingerprint submission:

I swear that I have been fingerprinted under Chapter 231, Florida Statutes, when employed as a teacher or non-instructional employee and have not been unemployed from the school board for more than 90 days. I swear the findings of that background check did not include any of the above offenses and that I meet the standards of good character for this caretaker position.

____
Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

____
Signature of Affiant

Sworn to and subscribed before me this ________ day of ________________, 19____.

______________________ My commission expires

______________________________ NOTARY PUBLIC, STATE OF FLORIDA

My signature, as a Notary Public, verifies the affiant's identification has been validated by:

____

STATE OF FLORIDA
WORKERS' COMPENSATION
SPECIAL DISABILITY TRUST FUND, S. 440.49, F.S.
EMPLOYEE/VOLUNTEER INFORMATION

Chapter 440, Florida Statutes, provides for recovery from the Special Disability Trust Fund where an injury merges with a pre-existing, permanent physical impairment to cause a greater disability than would have resulted from the injury alone. However, in order to recover from the Special Disability Trust Fund, it is required that the State has knowledge of this impairment prior to the occurrence of the compensable injury. In addition to a general category of impairments, there are certain specific impairments outlined by the above statutes. Therefore, the following questions are to be answered by each employee and volunteer.

1. Have you ever had a serious illness, injury, or operation? YES _____ NO _____

2. Have you ever received Workers' Compensation benefits for an injury? YES _____ NO _____

3. Do you now have, or have you ever had, any disability rating, either temporary or permanent, assigned to you by an insurance company or governmental agency, either federal, state, county, or city YES _____ NO _____

4. Do you now have, or have you ever had, any physical handicap or disability including the following? If so, please circle.

Epilepsy	Diabetes	Cardiac Disease	Multiple Sclerosis
Cerebral Palsy	Vascular Disorder	Parkinson's Disease	Chronic Osteomyelitis
Hemophilia	Hyperinsulinism	Muscular Dystrophy	Marie-Strumpell Disease
Thrombophlebitis	Total Deafness	Mental Retardation	

5. Have you ever had, or do you now have, back trouble or complaints? YES _____ NO _____

6. Have you ever had:
   a. Amputation of foot, leg, arm, or hand? YES _____ NO _____
   b. Total loss of sight in one or both eyes, or a partial loss of corrected vision of more than 75 percent bilaterally? YES _____ NO _____
   c. Herniated intervertebral disc? YES _____ NO _____
   d. Surgical removal of an intervertebral disc or spinal fusion? YES _____ NO _____
   e. Residual disability from poliomyelitis? YES _____ NO _____
   f. Psychoneurotic, emotional, or nervous disorder? YES _____ NO _____
   g. Ankylosis of a major weight-bearing joint? YES _____ NO _____
   h. Any permanent physical condition that constitutes a 20 percent impairment of a member, or of the body as a whole? YES _____ NO _____

Explain all <u>YES</u> answers. (Use additional sheets if needed.) ____________________________________

____

____

____

______________________________________ ______________________
Signature of Employee/Volunteer Date

______________________________________ ______________________
Reviewed by Supervisor Date

DH 1585, 12/97

State of Florida
DEPARTMENT OF HEALTH

VOLUNTEER SERVICES CODE OF ETHICS

DOH Volunteers are subject to a code of ethics similar to that of employees. The department expects volunteers to do their assigned tasks and to be accountable for the quantity and quality of their work.

Volunteers make a firm commitment of their time, talents and skills for a definite period of time. If they cannot report for duty, volunteers are to notify their supervisor and client.

Volunteers will conduct themselves in a professional manner, with dignity and courtesy at all times.

Volunteers will keep confidential all information they may learn directly or indirectly about a client or fellow worker. Volunteers will only seek information on a client that is important to the performance of an assigned task.

Volunteers will take any problems, criticisms or suggestions directly to their supervisor or to the volunteer service center specialist.

Volunteers will bring to their work an attitude of open-mindedness and a willingness for training and supervision. They will follow department policies and procedures.

Each person, whether paid or unpaid, brings their own unique gifts to the department. Volunteers enrich the department and the lives of DOH clients.

Volunteers will attend conferences and meetings as directed by their supervisor. They will record their volunteer time.

I have read this Code of Ethics and agree to abide by it.

Volunteer

Volunteer Coordinator

Date

Form 1496, Mar 97

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