



4405 DeSoto Road, Sarasota, Florida 34235

Volunteer Application

Please Print

Name: _____ Date: ____ / ____ / ____ Date of Birth: _____

Address: _____ City: _____ Phone _____

Have you ever worked with developmentally disabled children or adults? Yes No

If "yes" please elaborate: _____

Have you ever worked with children? Yes No If "yes" please elaborate:

Do you have children? Grandchildren? Are you in good health?

Do you have a health problem we should know about which will enter into your work with us? If "yes", please describe:

Do you have any special training or interest that could be used at our Agency?

Have you done volunteer work before? Yes No Where?

How were you helpful? _____

Do you prefer to work in a specific program? _____

How did you learn about our Agency: _____

What days and time would you prefer to volunteer: _____

Name: _____

Date: _____

Please list the names and addresses of three people you have been associated with for at least two years, but who are not related to you. (Please Print)

1. Name _____
Mailing Address: _____
2. Name _____
Mailing Address: _____
3. Name _____
Mailing Address: _____

Employment History:

Please furnish the following information on your most recent employment. (Please Print)

1. Name of Employer: _____ Phone: _____
Mailing Address: _____
Positions Held: _____ Supervisor: _____
2. Name of Employer: _____ Phone: _____
Mailing Address: _____
Positions Held: _____ Supervisor: _____

Client Confidentiality

All information concerning Community Haven for Adults and Children with Disabilities, Inc. clients is considered confidential. This includes all written and verbal information relating to clients and/or families.

This Agency adheres to confidentiality of clients as stated in the Bill of Rights of Persons who are developmentally disabled, as well as all persons with disabilities served by Community Haven for Adults and Children with Disabilities, Inc.

I agree to respect and comply with the civil rights in regard to client confidentiality and know that any intentional breach of these rights could result in my dismissal from volunteer status with Community Haven for Adults and Children with Disabilities, Inc.

Volunteer Signature

Date

Emergency Information

Please Print

Full Name: _____

Home Address: _____

Home Telephone Number: _____

Beginning Date of Volunteer Service: _____

Volunteer Service you are performing: _____

Person(s) to Contact in Case of Emergency:

1. Name: _____

Address: _____

Daytime Phone No. _____

2. Name: _____

Address: _____

Daytime Phone No. _____

I give Community Haven and Adult Community Services, Inc. permission to consult the noted physician below (or health resources) in an emergency, if the person(s) above cannot be reached.

Physician's Name: _____

Physician's Phone: _____

Preferred Hospital: _____

Volunteer's Signature

Date



4405 DeSoto Rd., Sarasota, FL 34235, 941-355-8808

LLE

Request for Local Law Enforcement Check for Applicants/Employee

To: Sheriff's Department
Attention: Records Department

Pursuant to Chapter 85-54, Laws of Florida, COMMUNITY HAVEN FOR ADULTS AND CHILDREN WITH DISABILITIES, INC. requests local records check for the applicant listed below:

_____	_____	_____	_____
Last Name	Maiden/Prior Married	Middle Name	First Name
_____	_____	_____	_____
Date of Birth	Race	Sex	Social Security #

Please document the findings of this check and return the information to the above address or return to the employee who will bring this form to our Human Resources Dept.

I hereby authorize Community Haven for Adults and Children with Disabilities, Inc. to check any and all records pertaining to criminal convictions and for any law enforcement agency to release to Community Haven for Adults and Children with Disabilities, Inc. information regarding convictions under Florida Statutes or statutes of other jurisdictions.

Date

Applicant Signature



4405 Desoto Road, Sarasota, FL 34235
Telephone: 941-355-8808 Fax: 941-359-8520

Mantoux Tuberculin Purified Protein Derivative Skin Test

Consent Form

Name: _____ Company: Community Haven

Administration 0.1 ml Mantoux Tuberculin Purified Protein Derivative Injected Intro-Cutaneously

Date of Test: _____ Site: _____ Administered by: _____

Date Test Read: _____ Result: _____ Read by: _____

I have requested the administration of a PPD skin test. I understand a localized reaction may occur at the site of the PPD in highly sensitive persons. Pain, itching and discomfort at the site may be relieved by applying a cold compress. The results of this test shall be read 48 to 72 hours after administration.

If positive, I understand it shall be my responsibility for further follow-up with the local Health Department or a private physician.

There have been no reported effects of the PPD on the fetus of a pregnant woman; however, you may want to check with your obstetrician prior to receiving it if you are pregnant.

I HAVE READ THE ABOVE INFORMATION AND I AM GIVING CONSENT TO ADMINISTER THE PPD SKIN TEST.

Signature

Date