



CARE 4 U
COMMUNITY HEALTH CENTER
“Because We Care!”

VOLUNTEER APPLICATION

PLEASE FILL OUT THIS APPLICATION COMPLETELY

It is very important that you provide accurate contact information so that we can reach you. If you have any questions or need any assistance with completing this application please let us know.

4690 NW 7th Avenue
Miami, Florida 33127
(305) 835-0101

Fax: (305) 835-0102 | Email: info@care4uchc.org | Web: care4uchc.org

VOLUNTEER APPLICATION

Care 4 U Community Health Center encourages the participation of volunteers who support our mission and vision. If you agree with our mission and vision and are willing to be interviewed and trained in our procedures, we encourage you to complete this application. The information on this form will be kept confidential and will help us find the most satisfying and appropriate volunteer opportunity for you. Thank you for your interest in our organization.

PERSONAL INFORMATION

Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City State Zip Code Email: _____
DOB: _____
Employer: _____ Occupation: _____
Address: _____ Phone: _____
City State Zip Code Email: _____

Do you have a valid driver license? Yes No Do you have car insurance? Yes No

INTEREST AND SKILLS

How did you hear about Care 4 U Community Health Center?

Patient Family/Friend Facebook
 Website Attended Event Other: _____

Why are you interested in volunteering at Care 4 U Community Health Center?

What talents and skills do you have that would benefit our organization?

LANGUAGES

English	<input type="checkbox"/> Understand	<input type="checkbox"/> Read	<input type="checkbox"/> Speak	<input type="checkbox"/> Write
Spanish	<input type="checkbox"/> Understand	<input type="checkbox"/> Read	<input type="checkbox"/> Speak	<input type="checkbox"/> Write
Creole	<input type="checkbox"/> Understand	<input type="checkbox"/> Read	<input type="checkbox"/> Speak	<input type="checkbox"/> Write
Other: _____	<input type="checkbox"/> Understand	<input type="checkbox"/> Read	<input type="checkbox"/> Speak	<input type="checkbox"/> Write

AVAILABILITY

Please indicate what days and times you are available.

Do you have any physical limitations? Yes No If yes, what limitation? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____

City State Zip Code Email: _____

CRIMINAL BACKGROUND

All potential volunteers are required by law to be screened pursuant to 435.04 of the Florida Statutes. The potential employee must undergo security background investigations as a condition of employment and continued employment which includes, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.

Have you ever been convicted of a crime including a felony traffic offense? Yes No (Note that answering yes to this question will not necessarily prohibit you from volunteering with Care 4 U Community Health Center.)

Depending on the nature of the crime, it may limit your employment opportunity. However, we ask that you respond to this question truthfully. We realize that no one is perfect, and people make mistakes.)

If yes, what were you convicted of? _____

AFFIDAVIT CONFIDENTIALITY OF UNDERSTANDING

I understand that as a volunteer of CARE 4 U COMMUNITY HEALTH CENTER, I am required by state law, 39.0132 (4) (a) and 39.202, F.S. to hold all CARE 4 U COMMUNITY HEALTH CENTER, program participant information obtained during my employment as "SUPERCONFIDENTIAL". I further understand that I cannot release any confidential information to any person or entity unless specifically authorized in writing by the client.

Further, I understand that there are strict procedures, which I must adhere to, for all programs clients under HIPPA and I will work and/or interact in coordinating client services concerning the exchange and release of information with the client making certain to maintain confidentiality and follow all rules and applicable laws.

Further, I understand that I may be guilty of a misdemeanor of the second degree and/or liable to civil suit if I violate that confidentiality.

Further, I understand that whether confidentiality is breeched directly or indirectly it will constitute grounds for disciplinary action and/or my immediate dismissal as a volunteer of Care 4 U Community Health Center.

Signature

Date

VOLUNTEER AGREEMENT

As a volunteer of our organization I agree to abide by the policies and procedures. I understand that I will be volunteering at my own risk and that the organization, its employees and affiliates, cannot assume any responsibility for any liability for any accident, injury or health problem which may arise from any volunteer work I perform for the organization. I agree that all the work I do is on a volunteer basis and I am not eligible to receive any monetary payment or reward.

Signature

Date