

Volunteer Application – Page 2

Have you submitted an application here before? Yes No If yes, please give dates _____

Accepted? Yes No Have you ever been bonded? Yes No

Have you ever been convicted of a crime? (A conviction will not necessarily disqualify you). Yes No

If yes, explain giving nature, location and date(s) of conviction _____

Have you ever been found liable or participated in a civil action for Intentional Tort? Yes No (An Intentional tort is a wrongful act a person intends to do which results in or involves a high risk of harm to the person or property of others, such as Assault, Battery, Defamation, Slander, False Imprisonment, or Trespass).

If yes, explain giving nature, location and dates of action taken _____

Skills & Qualifications:

Summarize any special training, computer skills, licenses and/or certificates that may qualify you as being able to perform job-related functions as a volunteer: _____

Licenses and Certifications:

Please indicate below and include a copy of the following Florida licenses and/or certifications you possess.

RN LPN CNA HHA LCSW CPR Certificate

Massage Therapist Food Handler FL Drivers License

Registered Pharmacist Pharmacy Tech Certificate Chaplain

License/Certificate # _____ Expiration Date _____

Education Background:

School Attended	Check if Graduated	Degree/ Diploma	Years Attended	Major/Minor	GPA or Class Rank

References:

Please list THREE responsible persons other than relatives and past employers who have knowledge of your qualifications for being a volunteer.

Name	Telephone		Years Known
	Work ()	Home ()	
	Work ()	Home ()	
	Work ()	Home ()	

Additional Information:

List professional, trade, business or civic associations and any offices held. **Exclude memberships which would reveal sex, race, religion, national origin, age, color, disability or any other similarly protected status.**

Organization	Offices Held

Military Experience:

Are you a veteran of the Armed Forces? ____ Yes ____ No
 If Yes, please identify your branch of service _____.
 Years of service _____ to _____.

FAILURE TO SIGN OR ANSWER ANY OF THE QUESTIONS ON THIS APPLICATION WILL RESULT IN THE REJECTION OF THIS APPLICATION.

I certify that the answers given herein are true and complete to the best of my knowledge. I understand that any misrepresentations, omissions of facts, or incomplete answers in any application document will disqualify me from further consideration. I further understand that any misrepresentations or omissions of facts in any application document will result in my dismissal without prior notice regardless of when such misrepresentation or omission is discovered.

I authorize Hospice of Marion County to contact and obtain information from all references, employers, educational institutions and to otherwise certify the accuracy of the information contained in this application. I further authorize Hospice of Marion County, Inc. to secure all job related information about me including, but not limited to, criminal background checks, motor vehicle checks and credit checks (if applicable). By signing I give my consent for Hospice of Marion County to disclose all employee personnel files and information obtained from various background investigations to Its Affiliates (Hospice of Marion County, Inc., Florida Palliative Home Care of Lake, Marion and Sumter Counties, LLC, Florida Palliative

Pharmacy & Equipment, LLC (dba Accent Medical, Summerfield Suites, LLC.) I hereby release from liability the Hospice of Marion County and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations furnishing information. I understand and agree that the receipt by Hospice of Marion County of any negative references or information could result in disqualification of acceptance or accepted dismissal as a volunteer without prior notice.

Hospice of Marion County does not unlawfully discriminate and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for volunteering on a basis prohibited by local, state or federal law.

This application will remain active for 90 days from the date received. At the conclusion of this time, if you have not heard from Hospice of Marion County and still wish to be considered as a volunteer, it will be necessary to complete a new application.

I understand that I am free to resign at any time, with or without cause and without prior notice, and Hospice of Marion County and It's Affiliated Companies reserves the same right to terminate as a volunteer at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for any authority to make any assurance to the contrary. I further understand that any such assurance must be in writing and signed by an authorized officer.

I understand it is the Hospice of Marion County's policy not to refuse a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA.

I also understand that I will be required to provide proof of identity.

I have read and fully understand the foregoing and will abide by its terms and conditions.

Signature of Applicant _____
Required for Processing

Date _____