



P O Box 2142
Santa Rosa Beach, FL 32459
850-622-3200 Fax: 850-622-5434

Volunteer Involvement Form for Community Volunteers

Name _____

First

Middle

Last

Today's Date: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) _____ Business Phone: (____) _____

Email Address*: _____

***Your email address is very important to us as we are transitioning to electronic communications.**

Emergency Contact Information

Contact Name _____ Relationship: _____

Address: _____ Phone: _____

Name of your Doctor: _____ Phone: _____

In case of emergency, is there anything we need to know (i.e. diabetic, etc.)?

The following information is only for the purpose of statistical records and in no way influences your opportunity to work in the program. It will be kept confidential and will aid us in future volunteer recruitment.

Occupation or previous occupation: _____

Schedule Availability

Monday Tuesday Wednesday Thursday Friday Morning / Afternoon

What kind of experience have you had working with children? _____?

Do you have any previous experience working in health care? If so, what type of experience? _____

Do you have any skills that you feel could be useful to Children's Volunteer Health Network? _____

Assignment Preference

- Mobile Dental Clinic
- Grant Writing
- Speaking to Groups about CVHN
- Translation. Language: _____
- CVHN Office: Help with clerical tasks and projects as needed
- Transportation: Provide transportation for children and families to their children's doctor appointments.
- Projects _____
- Special Events _____
- Other: _____
- Community Event _____
- Fundraisers

Confidentiality Agreement

As a volunteer working with the *Children's Volunteer Health Network* I, _____ agree not to divulge any information obtained in the course of my involvement with the children and their families. I will not publish, or in any way make public information regarding persons who receive services so as to identify them.

I understand that the unauthorized release of confidential information will result in dismissal from volunteer duties and may result in civil action or fines against me and the school district. This would also result in the closure of the program by the Board of Education.

Signature: _____ Date: _____

Please mail this form to:
Children's Volunteer Health Network
P O Box 2142
Santa Rosa Beach, FL 32459
Or fax to: 850-622-5434