



GEORGIA VOLUNTEER HEALTH CARE PROGRAM VOLUNTEER ENROLLMENT APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone Home Telephone Cell Phone

Email Address Emergency Contact Name Telephone Number

List any special considerations or needs: _____

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

NAME	NAME
ADDRESS	ADDRESS
CITY/STATE ZIP	CITY/STATE ZIP
PHONE	PHONE

List your most recent Volunteer and employment experience for the past ten years:

Employer	Supervisor	Address	Telephone

Length of Employment	Reasons for Leaving	Brief Job Description

Specify the days and time frames you are available to Volunteer:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Times						

Have you plead guilty, entered a plea of nolo contendere, or been found guilty of any crime by a judge or jury in any state or federal court?

Yes _____ No _____ If answer is yes, please explain (including types of offenses and dates):

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 of Community Health (DCH), 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; however, certain convictions will exclude me from Volunteering. 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 upon submission of this application it becomes public record.

I understand and agree that all information as it relates to persons served by the DCH is to be held confidential in compliance with the Georgia Code or any applicable state or federal law. 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 understand, acknowledge, and agree that I shall be considered a state officer or employee for purposes of Article 2 of Chapter 21 of Title 50 of Georgia Code Annotated as long as I act within the scope of Services defined pursuant to the job description. More specifically, governmental immunity shall only extend to me in the provision of being a support staff for health care providers contracted with the DCH. Notwithstanding the foregoing, applicable Georgia laws and rules and regulations directly or indirectly relating to state employment, worker's compensation, unemployment, collective bargaining, hours of work, rates of compensation, leave time, or employee benefits shall not be applicable to me.

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: _____

Date Screening Completed: _____ Supervisor's Name: _____

Name/Date Training Completed: _____

**WORK ASSIGNMENT
(For Agency Use Only)**

Clinic Location

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 Office of Constituent Services, 55 Trinity Avenue, Atlanta, Georgia 30303, (404) 330-6026, FAX: (404) 658-7088; wrivera@atlanta.gov.