FLORIDA DEPARTMENT OF HEALTH

Attachment 2

VOLUNTEER SERVICES RECORDS (Background) CHECK

I, _____
Print Full Name: First Middle Last (Maiden, If Applicable)

hereby grant permission to the Department of Health to obtain information from local and state law enforcement agencies to help determine my suitability to serve as a Department of Health volunteer.

I understand that if the records check show any violations committed or other information about my background that would indicate unsuitability or risk, I may not be accepted into the Department of Health Volunteer Program.

_____ _____
Social Security Number Date of Birth

_____
Complete Address City State Zip

_____
Sex/Race

_____ _____
Signature of Volunteer Date

NAME AND ADDRESS OF COUNTY HEALTH DEPARTMENT:

_____
_____
_____
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