



VOLUNTEER APPLICATION

Hampton Health Department Volunteer Services Program

Thank you for your interest in volunteering with the Hampton Health Department (HHD). Completion of the following will assist us in identifying a volunteer position for you. Volunteer placement is conditional based on the needs of the organization and the skills and availability of the applicant. **PLEASE PRINT LEGIBLY.**

Personal Information

Full Legal Name _____

Check one: Mr. Mrs. Ms. Dr. Other _____

Nick Name (if different from legal name) _____

Phone (Home) (____) _____ (Office) (____) _____ (Cell) (____) _____

Address _____

City _____ State _____ Zip _____

E-mail Address _____

SSN _____ Birthdate _____

Emergency Contact

Please list your contact person in case of injury or illness while volunteering:

Name (Last Name/First Name) _____ Relationship _____

Phone (Home) (____) _____ (Office) (____) _____ (Cell) (____) _____

Address _____

City _____ State _____ Zip _____

OK to contact at all the above phone numbers

Volunteer Interest

What type of opportunity interests you? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Working with the general public | <input type="checkbox"/> Working independently |
| <input type="checkbox"/> Working behind the scenes | <input type="checkbox"/> Working as part of a team |
| <input type="checkbox"/> Supervising a team | |

I am interested in being considered for: (Check all that apply)

- Administrative Support Volunteer (provides administrative support to HHD clinics/programs)
- Event Volunteer (provides a variety of event support for HHD special clinics/events)
- On-Call Volunteer (provides last minute administrative or event support)

Starting with the most recent, describe all paid, military, and applicable volunteer experience. If you have a current resume, you may attach it and skip this section.

Employer	Job Title	Job Responsibilities

Legal Information

Have you ever been convicted of a law violation(s), including all traffic violations? Yes No

If YES, please provide the following (a conviction does not automatically mean that you will not be hired):

Description of offense:

Statute or ordinance (if known) _____ Date of charge _____

County, City, State of conviction _____ Date of conviction _____

Other Information

Have you ever worked or volunteered for the City of Hampton or Hampton Health Department? Yes No

If yes, what department? _____ When _____

Do you have any disability or physical condition which should be taken into consideration when assigning you work?

Yes No If yes, please specify. (A disability will not prevent you from volunteering, if you are able to perform the duties of the job.) _____

References

Please list the names, addresses, telephone numbers and relationships of three individuals, not related to you, who can provide information regarding your skills and abilities.

Name	Address	Phone	Relationship	OK to Contact

Statement of Agreement

I hereby certify that all entries on this application are true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part to any rights in service to the *Hampton Health Department*.

I understand that all information on this application is subject to verification and I consent to a criminal background investigation. I also consent to references and former employers (professional or volunteer) and educational institutions listed being contacted regarding this application. I further authorize the *Hampton Health Department* to rely upon and use, as it sees fit, any information received from such contacts.

I understand that in the course of my volunteer work for the *Hampton Health Department*, I may learn facts about individuals being served that are of a highly personal and confidential nature. I agree not to disclose any information to any person not affiliated with *Hampton Health Department* and not authorized by *Hampton Health Department* to have such information.

Volunteer's Signature

Date

If volunteer is a minor (under 18 years of age):

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

Send completed application to:
Hampton Health Department
Attn: Volunteer Coordinator
3130 Victoria Boulevard
Hampton, VA 23661

For questions, call or e-mail:
(757) 727-1172, ext. 53781
Lesley.DeVries@vdh.virginia.gov
Robin.Williford@vdh.virginia.gov

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