1725 Hermitage Blvd.
Tallahassee, Florida 32308
Phone 850-325-6301
Fax 850-325-6302
volunteering@progressivepediatric.org

Dear Future Volunteer,

Thank you for your interest in volunteering with Progressive Pediatric.

Progressive Pediatric Developmental Center is a new non-profit organization that provides a multi-disciplinary approach to education and therapies. We provide an array of services for children with and without disabilities and their families. In addition to providing quality care in a nurturing environment, we believe that every child has the potential to succeed.

The process in becoming a volunteer with Progressive Pediatric is as follows:

- Complete a Volunteer Enrollment Form
- Complete a Volunteer Affidavit
- Get the Affidavit of Good Moral Character Notarized
- Complete a Level 2 Background Screening
    - www.identogo.com
    - You will need the following numbers as well as a picture ID when you go to get your fingerprints completed:
        - Department of Children and Families (DCF):
            ORI #: EDCFGN10Z
            OCA#: 02370102Z
- Attend a Volunteer Orientation and Facility Tour
- Create your schedule with the Volunteer Coordinator

Thank you once again for expressing an interest in volunteering with Progressive Pediatric Developmental Center. We look forward to working with you.

Sincerely,

*Beth Spear*

Asst. Executive Director


# Volunteer Enrollment Form

Name: _____

Address: _____

_____ Zip Code: _____

Telephone: (daytime)_____

(evening) _____

Email: _____

Social Security #: _____ Birth Date: ___/___/____

Employer/School: _____

Emergency Contact: _____ Relationship: _____

Emergency Telephone: _____

**Office Use**

Interviewer: _____

Date: _____

Orientation Date: _____

Volunteer ID#: _____

Dept Assigned: _____

Supervisor: _____

What experience/background would you like to use in volunteer work?

_____

_____

How did you hear about us?

_____

_____

Is this a requirement for a class? _____ YES _____ NO If yes, what class? _____

What is your preferred volunteering schedule?

| Hrs Avail. | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| Morning | | | | | | | |
| Afternoon | | | | | | | |
| Evening | | | | | | | |

Career/Volunteer Experience:

_____

_____

_____

_____

## REFERENCES

Please list the names, addresses, and telephone numbers of two personal references that you have known for a minimum of one year. (***Please do not use family members as a personal reference***).

Name: _____

Address: _____

City and State: _____ Zip code: _____

Phone: (Home) _____ (work) _____

**Office Use**
Comments: _____
_____
_____

Name: _____

Address: _____

City and State: _____ Zip code: _____

Phone: (Home) _____ (work) _____

**Office Use**
Comments: _____
_____
_____

I authorize Progressive Pediatric to verify information in this application and to perform a check of my background as it applies to the volunteer jobs in which I expressed an interest. I have no objection to having my record cleared through appropriate law enforcement agencies. I understand that all such information collected during the check will be kept confidential.
_____ (Initials)

I do hereby grant and convey unto Progressive Pediatric all rights, titles, and interest in and to any and all photographic images and video or audio recordings made by or on behalf of Progressive Pediatric, or made with its consent, during my volunteering with Progressive Pediatric and/or any project, activity, or event sponsored, managed, arranged, or promoted by or otherwise affiliated or associated with Progressive Pediatric, including but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings. _____ (Initials)

By signing below, I acknowledge that I have read and understand this Release, and agree to its provisions.

Signature: _____ Date: _____

1725 Hermitage Blvd.
Tallahassee, Florida 32308
Phone 850-325-6301
Fax 850-325-6302

## Confidentiality Form

Per HIPAA regulations, every person that attends, observes, or assists with a therapy or educational session at Progressive Pediatric is not to discuss the clients that receive therapies or services at this location. It is against the law to discuss clients using their name and/or any other pertinent information that is heard or seen in the clinic environment.

If you are a student, you may discuss the treatment and diagnosis of a child using generalizations. For example: *A client with Down syndrome was treated using the NDT theory, placed prone on a ball to increase head and trunk control.*

Volunteers are absolutely forbidden to take any documentation containing a child's name or personal information out of the clinic environment.

By signing below, you acknowledge that you understand and will comply with HIPAA standards.

Volunteer Printed Name: _____ Date: _____

Volunteer Signature: _____

Staff Initials: _____


1725 Hermitage Blvd.
Tallahassee, Florida 32308
Phone 850-325-6301
Fax 850-325-6302

Volunteer Name: _____ Date: _____

Email: _____ Volunteering Area/Duty: _____

| Date | Start Time | End Time | Total Time | Volunteered With... | Staff Verification |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |