MENTOR/ VOLUNTEER APPLICATION

Please Return to Penny Oranburg, LMHC
Poranburg@mentalhealthpbc.org
909 Fern Street West Palm Beach FL. 33401
Fax: (561) 660-8000

Date: _____

Name:_____
(First) (Middle) (Last)

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____Work Number:_____

Cell:_____E-Mail Address:_____

Driver's License No._____

Emergency Contact Information:

Name:_____Phone Number:_____

Relationship:_____

How did you hear about our agency?_____

Have you ever been charged or convicted of any felony charges? (Circle one)

Yes No If yes, Please elaborate:_____

Have you ever been charged or convicted of any misdemeanor charges? (Circle one)

Yes No If yes, Please elaborate:_____

Mental Health America of Palm Beach County

EDUCATION

Level	Name	Major	Circle Highest Grade Completed	Degree/Diploma/GED
High School			9 10 11 12	
College			1 2 3 4	
Other			1 2 3 4	

WORK HISTORY

Dates Employed	Company Name & Address
1.	
2.	
3.	

Professional Licenses:_____

Do you have any special computer or technical skills and trainings:_____

_____

Is there anything in addition that you would like us to know about you as it pertains to volunteering with Listen to Children?

_____

_____

_____

CONFIDENTIALITY AND DISCLOSURE

I understand and accept that the Mental Health America is governed by confidentiality rules. I will only disclose information in a confidential manner to the designated personnel or MHA Staff Members.

I also understand that if any person I am meeting with disclosed having been abused, abandoned or neglected, I must report it and call **1-800-96-ABUSE, THE TOLL FREE.** Abuse Hotline in Tallahassee. As an adult citizen, I am **LEGALLY** required to call and report this information.

PLEDGE OF CONFIDENTIALITY

I,_____, as a volunteer of the Mental Health America of Palm Beach County, Inc. understand that in the course of my work, I may learn certain facts about individuals being served that are of a highly personal and confidential nature. Examples of such information include, but are not limited to, medical and psychological diagnosis and treatment, finances, living arrangements, employment, relations with family members and the like. I understand that all such information must be treated as completely confidential. I agree not to disclose any information of a personal and confidential nature to any person not also affiliated with the Mental Health America and authorized by the Mental Health America without specific consent of the individual to whom such information pertains.

_____
Print Name

_____ _____
Signature Date

REFERENCE INFORMATION

Please list the names, addresses, and telephone numbers of three persons you would like to use as references (please list only people you have known at least one year). If appropriate, please provide an employer reference as one of your references. References may not be family members.

1.
Name_____ Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Relationship:_____

Email:_____

2.
Name_____ Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Relationship:_____

Email:_____

3.
Name_____ Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Relationship:_____

Email:_____

PHOTO AND VIDEO PRESS RELEASE

I,_____, do hereby give the Mental Health America of Palm Beach County their assigned licenses and legal representative the irrevocable right to use my name, picture, photograph, and visual likeness in all form and media in all manners, including photo, film, audio and video representations for nonprofit, public purposes, and I waive any right to inspect or approve the finished product that may be created in connection therewith. I have read this release and I am fully familiar with its content.

_____

Print Name

_____ _____

Signature of Applicant Date Signed

D-5-30

SUSPECTED CASES OF CHILD ABUSE, ABANDONMENT OR NEGLECT

Pursuant to § 39.201, Florida Statutes, all District employees, including teachers, administrators and no instructional staff who know or have reasonable cause to suspect, that a child is an abused, abandoned or neglected child, shall report such knowledge or suspicion immediately to the Department of Children and Families Central Abuse Hotline (1-800-96-ABUSE), twenty-four (24) hours a day. Persons making a report are required to provide their names to the hotline staff. The names of the reporter shall be entered into the record of the report, but shall remain confidential as provided in § 39.202, Florida Statute.

a. Immediately following the filing of a report to the Department of Children and Families Central Abuse Hotline, all school personnel shall notify the guidance counselor (and LTC Manager) of the school center. The principal shall notify the Area Executive Director.

b. No employee shall be disciplined, subject to reprisal or discharge for reporting a case of actual or suspected case of child abuse, abandonment or neglect if such report was made in good faith.

c. Each school center shall post a notice in a prominent place that all District employees have an affirmative duty to report all actual or suspected cases of child abuse, abandonment or neglect.

d. Definitions of child abuse, abandonment and neglect are:

   i. Physical abuse is any non-accidental physical injury or pattern of injuries inflicted or caused by an adult parent, parent-guardian or any other person;

   ii. Emotional abuse and neglect is a pattern of behavior that takes place over an extended period of time, characterized by intimidating, belittling, and otherwise damaging interaction that affects a child's healthy emotional development;

   iii. Sexual abuse is defined as exploitation of a child for the sexual gratification of an adult or person older than the child; and

   iv. Abandonment is defined as the marginal effort of a parent or legal custodian of a child or in the absence of a parent or legal custodian, the person responsible for the child's welfare, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligation.

   v. Neglect occurs when the parent or legal custodian of the child or, in the absence of a parent or legal custodian, the person primarily responsible for the child's welfare, deprives a child of necessary food, clothing, shelter or medical treatment or permits a child to live in a n environment when such deprivation or environment causes the child's physical, mental or emotional health to be significantly impaired.

Signature_____ **Date**_____

STATEMENT OF DIVERSITY

The Mental Health America of Palm Beach County, Inc., is committed to the promotion and affirmation of diversity in its broadest sense. Our mission requires that people of every background be able to access our services with an expectation of respectful treatment. In particular, prejudice and discrimination of the basis of gender, ethnicity, race, sexual orientation, age, physical and mental abilities, religious beliefs, and socioeconomic class run counter to our professional ethics as an agency.

DISABILITY POLICY

In compliance with the Americans with Disabilities Act, the Mental Health America welcomes individuals with disabilities. Volunteers should contact their Program manager and/or Director if they have special requirements; so the Association may arrange for accommodations. Medical services for non-occupational illness or injury are the responsibility of the individual and his/her personal physician.

This certifies that I have read and understand the aforementioned policies.

_____

Print Name

_____ _____

Signature Date

VERACITY OF INFORMATION

Our program appreciates your interest in becoming a volunteer. By signing below, you attest to the truthfulness of all information submitted on this application. You agree to allow our program to confirm all information listed and to conduct all reference and background checks listed in this application.

I have read and understand The Mental Health America of Palm Beach County, Inc., rules, regulations for becoming a volunteer. If selected, I agree to follow the rules.

_____

Print Name

_____ _____

Signature of Applicant Date

ACKNOWLEDGEMENT

I understand that any misrepresentation of any of the information stated above will result in my immediate dismissal as a Mental Health America volunteer.

_____

Print Name

_____ _____

Signature of Applicant **Date**

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