Brevard County Board of County Commissioners

BRAVE Program Volunteer and Intern Application

_____ _____ ___
Last name First name MI

_____
Street Address, City, State, Zip Code

_____ _____ _____
Phone Number Other phone Email address

_____ _____
Emergency contact name Relationship

_____
Emergency contact's phone number

Are you under 18? ☐ Yes ☐ No
If yes, parent or legal guardian signature is required.

1. How did you hear about the BRAVE program? _____

2. Are you looking for an Internship placement? ☐ Yes ☐ No
   (Note: Brevard County does not have a paid intern program)

3. Why are you interested in volunteering or interning with Brevard County Government?

_____

4. Is there a specific volunteer or intern position (or department) that interests you (if known) _____

5. Please list any previous volunteer or intern experience

_____

_____

6. Please list any special training or skills

_____

_____

7. Availability: Please state the hours you are available for each day

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

8. Length of time you are available (1 month, 6 months, indefinite, etc.)

_____

FOR INTERNSHIP APPLICANTS ONLY:

_____ _____

University/College Program Major

_____ _____

Semester Dates Required number of hours

Law Violation Record

Have you ever been convicted, pled nolo contendere, or had the adjudication of guilt withheld in connection with any criminal offense?

☐ Yes ☐ No If yes, please provide details (offense, date, place and disposition) on a separate sheet of paper. Note: A 'yes' answer to this question will not automatically bar you from volunteering. The nature, job-relatedness, severity and date of the offense in relation to the volunteer position will be considered.

READ THIS SECTION CAREFULLY BEFORE YOU SIGN

I certify that each answer to the questions in this application and all other information provided by me is true and correct to the best of my knowledge.

I understand that any misrepresentations of facts shall be considered basis for rejection of my BRAVE Volunteer/Intern application or discharge if accepted.

I understand that a background screening will be conducted as it applies to the volunteer assignment in which I have expressed an interest and I give my consent to the same.

I understand that all such information collected during the screening will be kept confidential.

I agree to abide by and comply with all rules, regulations, policies and practices of Brevard County Government and with all procedures established for volunteers.

I have read and understand the above.

I authorize Brevard County to verify information in this application.

Applicant's Signature _____ Date _____

Parental Permission (required for volunteers under age 18)

I hereby give my permission for my child to participate as a volunteer in the Brevard County Government's BRAVE Volunteer & Intern Program. I have read and understand the above.

Parent/Guardian Signature _____ Date _____

VOLUNTEER ACKNOWLEDGEMENT

Brevard County Board of County Commissioners encourages volunteer participation by individuals and groups in County departments, offices, and facilities. "Volunteer" means a person who, of his/her own free will, provides goods or services to any unit of County Government or to any County Charter Officer without receiving monetary or material compensation. The following are classes of volunteers:

DEFINITION:

a) "Regular-service volunteer" means a person engaged in specific voluntary service activities on an ongoing or continual basis.
b) "Occasional-service volunteer" means a person who offers to provide a one-time or occasional voluntary service.
c) "Material donor" means a person who provides funds, materials, employment or opportunities for clients of County Government without receiving monetary or material compensation. Specific Authority, Florida Statute FS 125.9501-06.

The State of Florida makes certain provision for volunteers who are injured while performing voluntary service activities. In the event of an accident resulting in injury or illness, volunteers are eligible for Workers' Compensation, medical benefits only, in accordance with Chapter 440, Florida Statutes.

VOLUNTEER REPORTING REQUIREMENTS:

In order to provide the most timely and suitable quality medical care in the event of an injury at the worksite where you are volunteering your services, the County provides access to primary care and occupational medicine physicians under our Workers' Compensation statutory obligations as a public entity employer.

The following procedures must be followed for all volunteer work-related injuries and/or illnesses. It is important to note that Florida Statute 440.134(17) states" ... Treatment received outside the Workers' Compensation Managed Care Arrangement is not compensable unless authorized by the carrier prior to the treatment date."

If you are injured while performing voluntary service activities:

Report your injury to a Supervisor/Manager immediately. When a Supervisor or Manager is unavailable during normal business hours, you may contact the Risk Management Office at (321) 633-2037 to report your injury.

IN CASE OF EMERGENCY OR LIFE-THREATENING INJURIES, SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST HOSPITAL.

Report promptly any volunteer work-related injury to a supervisor at the worksite. Follow the Primary Care Physician or "PCP's" instructions for any medical specialist referral or treatment.

Ensure all medical treatment is handled only through the PCP. Direct all questions about the level of care to the PCP, who is the focal point for all medical treatment.

Follow established grievance procedures to resolve any dissatisfaction with medical treatment and I understand that a grievance form and a copy of the grievance procedures will be provided to me in the event that I am injured at the volunteer worksite.

A directory of medical care providers and a manual explaining fully the managed care process is available and can be provided by asking a supervisor at the worksite where I am volunteering or may have volunteered my services.

Please sign below to indicate that you have read and understand what your responsibilities are and what procedures you should follow under our Managed Care Program in the event of an injury or illness.

Name (please print) _____ Date _____

Signature _____

Department _____

Parent Name _____ Date _____

Parent Signature _____

BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS
AUTHORIZATION TO RELEASE INFORMATION

Employee/Volunteer Name:

_____

Last First MI

Other legal names, such as names before marriage (i.e. maiden name) or legal name changes made by you:

_____

Applicant's current address:

_____

Street City State Zip Code

Applicant's Date of Birth: _____

Department/Agency contact person: _____

I, the undersigned, authorize and consent to any person, firm, organization, or corporation provided a copy (including photocopy or facsimile copy) of this **Authorization to Release Information** by the above-stated agency to release and disclose to such agency any and all information or records requested regarding me, including, but not necessarily limited to, my employment records, verification of education, volunteer experience, military records, criminal information records (if any), and background.

I have authorized this information to be released, either in writing or via telephone, in connection with my application for employment or to be a volunteer at the agency.

Any person, firm, organization, or corporation providing information or records in accordance with this authorization is released from any and all claims or liability for compliance.

Any information received will be held in confidence in accordance with agency guidelines.

Printed Name _____

Department _____

Signature _____

If Volunteer is under 18 a parent or legal guardian must sign this application.

Parent Name _____

Parent Signature _____

Date _____

*****ATTENTION DEPARTMENT/AGENCY*****
Send the signed copy to Human Resources
Form Revised 6/2020

ADDRESS HISTORY FORM

To be attached to the Background Investigation Checklist and submitted to Human Resources

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Please fill out this form for your address history based on the security level for the position. Two years for low level and 7 years for moderate level. The County representative will tell you how many years are required.

☐ **2 YEARS (low level)** ☐ **7 YEARS (moderate level)** **DATE: _____**

Applicant Name: _____ Date of Birth: _____

INSTRUCTIONS: Please fill out this form for your address history by listing the dates (from and to) and addresses of your residences for a FULL 2 or 7 years, as required for your security level, beginning with your current address. To avoid delayed processing please provide complete information for each address and time period.

From: _____ To: current Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

Address history continued… **Name _____**

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____

From: _____ To: _____ Street address: _____

City: _____ County: _____ State: ___ Zip: _____
