FLORIDA DEPARTMENT OF HEALTH

VOLUNTEER RECORD CHECK

I, _____, hereby grant
Print Full Name: First Middle Last (Maiden, if applicable)

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

_____ _____
Social Security Number Date of Birth

_____
Race/Sex

_____
Complete Address City State Zip

_____ _____
Signature Date

Exhibit J