

## **SPECIAL POPULATION VOLUNTEERS**

Volunteers are the backbone of the Special Community Services section of the Events Management Division and Leisure Services Department of the City of Altamonte Springs. They enable us to offer a wide variety of activities and programs for the Special Population in our community. When you volunteer, you join a family of people from all walks of life who gain a greater understanding of and appreciation for people with mental and physical disabilities.

As part of our volunteer process, the City of Altamonte Springs requires an affidavit to be signed by each volunteer and a Level 2 nationally fingerprint-based records check to be completed. This is done to better serve our Special Population by ensuring the safety of each participant.

### **HOW TO REGISTER:**

1. Complete the enclosed paperwork (includes a document requiring notary)
2. Return all forms to Special Needs Activities Coordinator.
3. Take a copy of the FDLE Form to be fingerprinted at the COPS Center in the Altamonte Mall
4. Await confirmation of approval
5. Select desired events to volunteer at via newsletter and website postings

### **ENCLOSED:**

1. Volunteer Information & Events Interest Form
  - o This form gives us a way to contact you and lets us know in which program(s) you would like to volunteer.
2. Report of Medical History Form
  - o This information is for official and medically-confidential use only and will not be released to unauthorized persons.
3. Collection of Social Security Number
  - o This form specifies how the collection of your social security number will be used.
4. FDLE Form (Fingerprinting Form)
  - o After completing this document, please make a copy for yourself and take it with you to be fingerprinted at the COPS Center in the Altamonte Mall.
5. Affidavit of Good Moral Character
  - o Please sign this document in the presence of a Notary Public.
  - o You may bring the document to the Altamonte COPS Center for notary services. Please call to confirm availability 407-571-8463

### **COPS CENTER LOCATION**

- Altamonte Springs Police Department's COPS Center is located at:  
Altamonte Mall, 451 E. Altamonte Drive, Alt. Springs FL 32701  
Just inside the lower level main mall entrance between JCPenney and Macy's
- Volunteers staff the COPS Center Monday through Saturday, from 10:00am until 4:00pm, offering fingerprinting, notary, safety literature, and more. Phone: 407-571-8463

Thank you for assisting us in providing socially interactive, therapeutic, and recreational activities for our Special Population. Please feel free to contact us if you have any questions or issues.

### **Ranwa Nin El-khoury, Special Needs Activities Coordinator**

City of Altamonte Springs, 225 Newburyport Avenue, Altamonte Springs FL 32701

Office: 407-571-8814, Fax: 407-571-8809, Email: [Rrel-Khoury@altamonte.org](mailto:Rrel-Khoury@altamonte.org)

[www.AltamonteSports.org](http://www.AltamonteSports.org), [www.AdvisoryBoardforDisabled.org](http://www.AdvisoryBoardforDisabled.org)

CITY OF ALTAMONTE SPRINGS - SPECIAL COMMUNITY SERVICES  
**VOLUNTEER INFORMATION & EVENTS INTEREST FORM**

Today's Date: \_\_\_\_\_

Volunteer Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Alternate Number: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Want to receive our E-Newsletter?**  Yes  No  Prefer mailed newsletter (mailed 3-4 per year)

**Please select all volunteer opportunities that interest you:**

- Nightbird Dances: one Friday night a month
- STOP Field Trips: Saturday Time Outs for Parents- one Saturday a month
- Bowling: every Monday, excluding holidays
- Thursday Night Out: Craft, Karaoke, & Game Night (Thursday Evenings)

- Winter Camp: 8 Wednesdays from January to February
- Summer Camp: 8 Wednesdays from June to July

- Belly Dancing: second and fourth Wednesday of the month
- Ballroom Dancing: (8 week workshops)
- Altamonte Sparklers: Special Needs Cheerleading Squad (October- April)

- Banquets: (Bowling, Belly Dancing, Holiday Gala)
- Fundraisers: (Set up, advertise, serve, or clean up)
- Office Work: (filing, mailing, data entry)

Other/Comments: \_\_\_\_\_

**Please return paperwork to:**

City of Altamonte Springs  
Attn: Ranwa Nin El-Khoury  
225 Newburyport Avenue  
Altamonte Springs, FL 32701  
Office: 407-571-8814  
Fax: 407-571-8809  
Email: [Rrel-Khoury@altamonte.org](mailto:Rrel-Khoury@altamonte.org)  
[www.AltamonteSports.org](http://www.AltamonteSports.org)  
[www.AdvisoryBoardforDisabled.org](http://www.AdvisoryBoardforDisabled.org)

<b>OFFICE USE ONLY:</b>
Affidavit: _____
Medical: _____
FDLE: _____
Social Sec: _____
Date Forwarded: _____
Date Cleared: _____
Comments: _____
_____

# REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NUMBER <i>Administrative and Recordkeeping Purposes</i>
3. DOB / MARITAL STATUS	4. HOME ADDRESS ( <i>Street, City, State, Zip Code</i> ) AND PHONE NUMBER
5. PERSONAL PHYSICIAN: ( <i>Name and address, Phone</i> )	6. PLEASE DESCRIBE YOUR PRESENT HEALTH:

7. HAVE YOU EVER HAD OR HAVE YOU NOW (*Check at left of each column*). For yes answers, explain fully in designated area on reverse side of this form.  
*Include type and frequency, your age at diagnosis, when, where and type of treatment.*

Yes	No	Don't Know	Check each item	Yes	No	Don't Know	Check each item	Yes	No	Don't Know	Check each item
			Tuberculosis or lived with anyone who had tuberculosis				Heart trouble, cardiac disease or vascular disorder				Pain or pressure in chest
			Lung Infections				Thrombophlebitis				Diabetes
			Coughed up blood				High or low blood pressure				Loss of memory/amnesia
			Eye problems/glasses/contacts				Neuritis or nervousness				Head Injury
			Total loss of sight in one or both eyes or partial loss of corrected vision of more than 75% bilaterally				Psychoneurotic disability after confinement for treatment in recognized medical facility for over 6 months				Tumor, growth, cyst, cancer
			Total deafness, hearing loss or wear a hearing aid				20% permanent impairment of a member or the body as a whole				Epilepsy
			Hemophilia or excessive bleeding				Loss of body part by amputation				Frequent or severe headache
			Recurrent back pain or wear brace or back support				Scarlet fever, erysipelas or rheumatic fever				Thyroid trouble
			Treated for back condition or injury				Ear, nose or throat trouble				Diphtheria
			Surgical removal of an intervertebral disk or spinal fusion				Speech problems, including stuttering or stammering				Adverse reaction to serum/drug or medicine
			Herniated intervertebral disk				Dermatitis or skin disease				Severe tooth or gum trouble
			Dizziness or fainting spells				Fungus				Foot trouble
			Periods of unconsciousness				Stomach/liver/intestinal trouble				Broken bones
			Cramps in your legs				Gall bladder trouble or gallstones				Rupture/hernia
			Bone, joint or other deformity				Frequent indigestion				Frequent trouble sleeping
			Arthritis, rheumatism, bursitis or swollen/painful or "trick" joints				Paralysis (including infantile)				Motion sickness (car, train, sea or air)
			Ankylosis in weight bearing joint				Lameness				Piles or rectal disease
			Chronic Osteomyelitis				Poliomyelitis				Frequent or painful urination
			Sinusitis, Hay Fever, Asthma				Multiple Sclerosis				Typhoid
			Shortness of breath				Cerebral Palsy				Kidney stones/blood in urine
			Respiratory disorders				Muscular Dystrophy				VD - syphilis, gonorrhea, etc.
			Chronic or frequent colds				Parkinsons' Disease				Marie Strumpell disease
			Chronic cough				Recent gain or loss of weight				Bacterial Infection
			Difficulty breathing while wearing a dust mask				Obesity, 30% or more overweight				Blood/other body fluid disorders
			Difficulty breathing while wearing a cartridge respirator				Jaundice				Been exposed to sulfur dioxide
			Difficulty breathing while wearing a self contained breathing apparatus				Hepatitis A, B or C				Been exposed to Chlorine gas
			Difficulty breathing in confined spaces				Sugar or albumin in urine				Tetanus
			Palpitation or pounding heart				Hyperinsulinism				

***Please complete reverse side***



# COLLECTION OF A SOCIAL SECURITY NUMBER

Your social security number is collected and may be used by the City of Altamonte Springs for the following purposes:

- Background Checks; (FCRA – Authorized)
- Workers' Compensation: (Chapter 440, FS, Section 440.185; & MMSEA Section 111 – Mandatory)
- Tax reporting: (IRC sections 3402(f)(2)(A) and 6109 and their regulations – Mandatory)
- Form I-9 – Employment Eligibility Verification (Department of Homeland Security – Authorized)
- Unemployment Reports (Florida Department of Revenue – Authorized)
- Group Health plans (MMSEA Section 111 – Mandatory)
- Educational Enrollment; (FI Statute 119.071(5) Mandatory)
- Retirement: (VII, chapter 112, F.S., for all local government plans, Internal Revenue Code, Title 26, Subtitle F, Chapter 61, Subchapter A, Part III, Subpart B, Section 6041. - Mandatory)

Note: Some of the above forms pertain to full time positions.

You will be informed if there are other circumstances not listed above where your social security number may be used.

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Applicant's Name (Please print)

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Date

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Applicant's Signature



# VECHS WAIVER AGREEMENT AND STATEMENT

**Volunteer & Employee Criminal History System (VECHS)**  
for Criminal History Record Checks  
under the National Child Protection Act of 1993, as amended,  
and Section 943.0542, Florida Statutes

Pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes, this form must be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize (**enter Name of Qualified Entity**) CITY OF ALTAMONTE SPRINGS to submit a set of my fingerprints and this form to the Florida Department of Law Enforcement for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes.

I understand that, until the criminal history background check is completed, you may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, you will provide me a copy of the criminal history background report, if any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

A national criminal history background check on me has previously been requested by:

\_\_\_\_\_  
(Name and Address of Previous Qualified Entity) (Year of Request)

I  have OR  have not been convicted of a crime.

If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:  
\_\_\_\_\_  
\_\_\_\_\_

I  do OR  do not authorize you to release my criminal history records, if any, to other qualified entities.

I am a current or prospective (check one): Employee  Volunteer  Contractor/Vendor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**TO BE COMPLETED BY QUALIFIED ENTITY:**

Entity Name: CITY OF ALTAMONTE SPRINGS

Address: 225 NEWBURYPORT AVENUE, ALTAMONTE SPRINGS, FL. 32701

Telephone: 407-571-8091 Fax: 407-571-8070

FDLE Assigned Qualified Entity Number: E59020014 OR V59020014

**ORIGINAL - MUST BE RETAINED BY QUALIFIED ENTITY  
COPY - SEND TO FDLE WITH FINGERPRINT CARD**

# AFFIDAVIT OF GOOD MORAL CHARACTER

STATE OF FLORIDA  
 COUNTY OF \_\_\_\_\_

ACTIVITY \_\_\_\_\_  
 CENTER \_\_\_\_\_

Before me this day personally appeared \_\_\_\_\_ who, being duly sworn, deposes and says:

As an applicant for employment in a position that deals directly with children, I hereby attest to meeting the requirements for employment, that I am of good moral character, that I have not been found guilty of, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction. I have not had a finding of delinquency or entered a plea of nolo contendere or guilty to a petition alleging delinquency pursuant to Part II, Chapter 39, Florida Statutes, or similar statutes of other jurisdictions, for any of the following acts. I understand I must acknowledge the existence of any criminal or delinquency record regardless of whether I was adjudged guilty by the court and regardless of whether or not those records have been sealed or expunged.

Section	415.111	abuse, neglect or exploitation of aged or disabled persons	Chapter	800	lewdness and indecent exposure
Section	741.30	domestic violence	Section	806.01	arson
Section	782.04	murder	Section	812.13	robbery
Section	782.07	manslaughter	Section	817.563	fraudulent sale
Section	782.071	vehicular homicide			controlled substances, only if the offense was a felony
Section	782.09	killing of an unborn child by injury to the mother			incest
Section	784.011	assault, if the victim of the offense was a minor	Section	826.04	aggravated child abuse
Section	784.021	aggravated assault	Section	827.03	child abuse
Section	784.03	battery, if the victim of the offense was a minor	Section	827.04	negligent treatment of children
Section	784.045	aggravated battery	Section	827.05	sexual performance by a child
Section	787.01	kidnapping			obscene literature
Section	787.02	false imprisonment	Section	827.071	drug abuse
Section	787.04	moving children from the state or concealing children contrary to court order	Chapter	847	prevention and control only if the offense was a felony or if any other person involved in the offense was a minor
Section	794.011	sexual battery	Chapter	893	
Section	794.041	prohibited acts or persons in familiar or custodial authority			
Chapter	796	prostitution			
Section	798.02	lewd and lascivious behavior			

I further attest that I have not been judicially determined to have committed abuse or neglect against a child as defined in s.39.01, Florida Statutes; nor do I have a confirmed report of abuse, neglect or exploitation as defined in s.415.102, or abuse or neglect as defined in s.415.503 which has been uncontested or upheld pursuant to the procedures provided in s.415.103 or s.415.504, Florida Statutes.

Under the penalty of perjury, I attest that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

\_\_\_\_\_  
Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

\_\_\_\_\_  
Affiant

The foregoing document was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as identification and who did (or did not) take an oath.

Notary Public

My Commission Expires: