



Long-Term Care Ombudsman Volunteer Application

PLEASE PRINT	
Name:	Email Address:
Address:	Cell Phone: () -
City, State, ZIP:	Home Phone: () -
County:	Date of birth (month/day): /
Is your primary residence in Florida? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, what percentage of time do you spend in the state? %	Do you have your own transportation? <input type="checkbox"/> YES <input type="checkbox"/> NO

VOLUNTEER EXPERIENCE
Please describe any volunteer experience you have including name of the organization and the duties you performed.

WORK EXPERIENCE		
Employer	Occupation/Position Held	Date (From/To)

EDUCATION	
Institution, City, State	Certificate, Degree, or Area of Study

QUALIFICATIONS
Please explain what skills, abilities and experience you would bring to this volunteer position.
Are you fluent in any languages other than English? If so, please describe.

CONFLICT OF INTEREST

Do you have a competing interest, obligation or duty which compromises, influences, or interferes with your objectivity or capacity to fulfill your duties as an ombudsman? YES NO If Yes, please explain.

AVAILABILITY

Which days and times are you generally available to volunteer?

Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time of Day							

CRIMINAL HISTORY

Have you ever been arrested, charged, convicted, or pled nolo contendere or guilty, or had the adjudication of guilt withheld for any violation of federal or state law ?
If Yes, describe the date (s) and offense (s).

YES
 NO

Note: Answering Yes to this question will not automatically make you ineligible to be an ombudsman .

Please list the name, address, and phone number of two people you have known for at least five years who are not family members.

Name	Address	Phone

EXEMPTION FROM PUBLIC RECORDS DISCLOSURE

Are you a current or former law enforcement officer, other employee** or the spouse or child of one, who is exempt from public records disclosure under §119.07(3)(k)1,F.S.? YES NO

** Other covered jobs include: correctional and correctional probation officers, firefighters, certain judges, assistant state attorneys, state attorneys, assistant and statewide prosecutors, personnel of the Department of Revenue or local governments whose responsibilities include revenue collection and enforcement or child support enforcement, and certain investigators in the Department of Children and Family Services [§119.07, F.S].

CERTIFICATION

I am aware that any omissions, falsifications, misstatements, or misrepresentations above may disqualify me for consideration as a volunteer and, if I am accepted, may be grounds for de-designation at a later date. I understand that any information I give may be investigated as allowed by law. I understand this application is a public record. I certify that to the best of my knowledge and belief all of the statements contained herein are true, correct, complete, and made in good faith.

Signature:

Date:

Please submit this application to:

Florida Long Term Care Ombudsman Program
4040 Esplanade Way
Tallahassee, FL 32399-7000
Call toll free (888) 831-0404 with any questions.