



Florida Institute of Technology

The Scott Center for Autism Treatment

VOLUNTEER APPLICATION

Please print clearly.

Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Florida Resident: Yes No

Emergency Contact Name _____ Phone _____

Please list any languages (other than English) that you speak _____

Education: High School Some College College Graduate School

College Major _____ Degree _____

Are you currently in school? Yes No Are you a full-time student? Yes No

Occupation _____ Employer _____ Length of Employment _____

Have you ever been convicted of a crime? Yes No

Please indicate your preference for training? Day Evening Weekend

Time/day you will be available to volunteer _____

Current/previous volunteer work _____

How long did you volunteer? _____ Reason for leaving? _____

What did you enjoy about your previous volunteer work? _____

Community/civic organization memberships _____

Hobbies/special interests _____

How did you hear about The Scott Center for Autism Treatment? _____

What do you hope to accomplish from your work at The Scott Center? _____

Please provide two references (non-family members) who have known you at least two years or longer:

1. Name _____ Phone _____

Address _____

2. Name _____ Phone _____

Address _____

VOLUNTEER SCREENING STATEMENT

I, _____, hereby authorize The Scott Center for Autism Treatment at Florida Institute of Technology to obtain information needed for purposes of background screening and reference checks. This may include contacting former employers, law enforcement agencies and personal references. A photocopy of this consent form shall be as valuable as the original.

Signature _____ Date _____

Florida Institute of Technology • The Scott Center for Autism Treatment

150 W. University Blvd., Melbourne, FL 32901 • Phone: (321) 674-8106 x1 • Fax: (321) 674-8411

PY-532-712