

COLLIER COUNTY SHERIFF'S OFFICE

Explorer's Program

Kevin J. Rambosk, Sheriff

AFFIX
PICTURE HERE

Name: _____ Race: _____ Sex: _____

Address: _____ Zip Code: _____

Age: _____ D.O.B.: _____ Name of Parent/Guardian: _____

Home Phone #: _____ Cell Phone #: _____ Parent Phone #: _____

Email: _____

Name of School: _____ Grade: _____

Have you ever been arrested? Yes No

Have you ever been in trouble at school? Yes No

Have you ever been treated for: Alcohol? Yes No

Illegal drug use? Yes No

Is there a medical condition we need to be aware of? Yes No

Do you take medication? Yes No

If you answered yes to any of the above questions, please explain: _____

Will you be able to attend training / meetings on a regular basis? Yes No

Violation of Florida State Statutes, the Explorer's Program by-laws, or disrespect to any Explorer member / advisor or the general public will be subject to suspension / dismissal from the program.

Random drug testing will be conducted for all Explorers participating in the CCSO Explorer Program.

Training and information you receive may be sensitive to Law Enforcement in nature and should not be disclosed outside the Law Enforcement environment. Failure to comply with this mandate will result in your immediate dismissal from the program.

Applicant

Date

Parent / Guardian

Explorer Advisor

DJJ Check Grade Average Approval (Senior Advisor) Approval (Explorer Supervisor)

Green Shirt

Date Issued

Date Returned

White Class B Shirt

Green Class B Pants

Explorer Badge

Tan Shirt

Revised 08/17/09

All issued property remains the property of the Collier County Sheriff's Office and must be returned when leaving the Explorer's program.

COMPLIANCE STATEMENT

I, _____ (Parent/Guardian Name),
have read the Explorer's Program packet in its entirety, including the calendar, and
agree to support my child's compliance in attending Explorer details, including
weekends.

Signed: _____ Date: _____

Printed Name: _____

TRAVEL PERMISSION FORM

I, _____ (Parent/Guardian Name),
grant my son/daughter, _____, to participate
in all Explorer activities and travel with the Explorer Advisors during functions and
meetings. Explorer Advisors / CCSO Deputies are authorized to obtain medical
treatment and care during my absence.

Signed: _____ Date: _____

Printed Name: _____

Witnessed: _____ Date: _____

Printed Name: _____

Insurance Company: _____

Policy #: _____

Parent Contact: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact Person: _____

Home #: _____ Work #: _____ Cell #: _____