



VOLUNTEER SERVICES APPLICATION

- Individual
Navy
Florida State University
Pensacola State College
University of West Florida
Other

Name (Last) (First) (Middle) (E-mail address)
Mailing Address City State Zip
Work Telephone Home Telephone Emergency Contact Person Telephone

Group Name and Leader (if applicable):

List any professional or occupation registration, license or certification you or your group hold (include certificate/license number):

List any special skills, interests or hobbies:

List three references not related to you whom you have known for more than one year.

Name: Mailing Address Telephone #
Name: Mailing Address Telephone #
Name: Mailing Address Telephone #

List your most recent volunteer or employment experience:

Employer Mailing Address Telephone #
Job title Dates of Employment/Volunteer

Circle the days you are available to volunteer: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Specify the hours you are available to volunteer: From To

Specify the DATES you are available: From To

Are you able and willing to transport patients using your vehicle? Yes No

Are you able and willing to transport patients in a state vehicle? Yes No

If yes, please provide your drivers license number:

Name of insurance carrier:

Have you ever been convicted of, or plead nolo contendere to a driving or criminal offense? Yes No

If yes, please explain (including type of offense and date):

It shall be a misdemeanor of the first degree to fail to disclose by false statement, misrepresentation, impersonations or other fraudulent means, to disclose any material fact used in making a determination as to a person's qualifications to work as a volunteer.

I understand that, to protect individuals served by the department, a routine check through law enforcement, license bureaus, agency files and references may be made. I understand that a criminal offense will not automatically exclude me from all volunteer positions; however, certain convictions will exclude me from volunteering in some positions. I understand that if I answered no to the criminal offense question on the front of this application and a record should be obtained, it will prevent me from volunteering for the department regardless of the offense. I understand that applications submitted for state volunteer services are public records.

I understand and agree that all information as it relates to persons served by the department are to be held confidential in compliance with Florida Statutes. All information that should come to my attention and knowledge as privileged and confidential will not be disclosed to anyone other than authorized personnel and that I shall conduct myself in accordance with the departmental security policies. I understand that failure to comply may result in criminal prosecution.

I affirm that all information on this application is true and correct.

Signature

Date

THE FOLLOWING INFORMATION IS NEEDED TO CONDUCT LAW ENFORCEMENT CHECKS.

SEX: MALE FEMALE DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

RACE (Check only one): WHITE BLACK HISPANIC ASIAN or PACIFIC ISLANDER NATIVE AMERICAN

OTHER (Specify): _____

INTERVIEWER'S COMMENTS
(For DOH-Escambia Use Only)

Date of Interview: _____

Interviewer's Name: _____

Volunteer placement approved by _____ on _____

This is: New Applicant Update

Type of Volunteer: Individual Group Intern/Practicum/Resident Community Services

Other (specify) _____

Screening Required: Yes No

Date Screening Completed: _____

Date Orientation Given: _____

WORK ASSIGNMENT
(For DOH-Escambia Use Only)

Program

Location

Supervisor

Date Placed

It is unlawful for an employer to refuse or deprive any individual or volunteer opportunities because of race, color, religion, sex, national origin, age, marital status, or handicap. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, 325 John Knox Road, Building F, Suite 240, Tallahassee, Florida 32399-1570.

**State of Florida
Department of Health**

**VOLUNTEER SERVICES
CODE OF ETHICS**

Florida Department of Health volunteers are subject to a code of ethics similar to that of employees. The department expects volunteers to do their assigned tasks and to be accountable for the quantity and quality of their work.

Volunteers make a firm commitment of their time, talents and skills for a definite period of time. If they cannot report for duty, volunteers are to notify their supervisor and client.

Volunteers will conduct themselves in a professional manner, with dignity and courtesy at all times.

Volunteers will keep confidential all information they may learn directly or indirectly about a client or fellow worker. Volunteers will only seek information on a client that is important to the performance of an assigned task.

Volunteers will take any problems, criticisms or suggestions directly to their supervisor or to the volunteer coordinator.

Volunteers will bring to their work an attitude of open-mindedness and willingness for training and supervision. They will follow department policies and procedures.

Each person, whether paid or unpaid, brings their own unique gifts to the department. Volunteers enrich the department and the lives of clients.

Volunteers will attend conferences and meetings as directed by their supervisor. They will record their volunteer time.

I have read this CODE OF ETHICS and agree to abide by it.

Volunteer Signature

Volunteer Coordinator Signature

Date



Computer Use and Confidentiality Agreement

SECTION A Members of the workforce (WF) and the appropriate supervisor or designee must address each item and initial.

Security and Confidentiality Supportive Data

WF Supv

- I have been advised of the location of and have access to the Florida Statutes and Administrative Rules.
- I have been advised of the location of and have access to the core Department of Health Policies, Protocols and Procedures and local operating procedures.

Position Related Security and Confidentiality Responsibilities

- I have been given copies or been advised of the location of the following specific Florida Statutes and Administrative Rules that pertain to my position responsibilities:
 - Chapter 815.04 Computer-Related Crimes _____
 - Chapter 384.29 Confidentiality _____
 - Chapter 381.04 Testing for Human Immunodeficiency Virus _____

- I have been given copies or been advised of the location of the following specific core Department of Health Policies, Protocols and Procedures that pertain to my position responsibilities:

- I have been given copies or been advised of the location of the following specific supplemental operating procedures that pertain to my position responsibilities:

- I have received instructions for maintaining the physical security and protection of confidential information, which are in place in my immediate work environment.

I have been given access to the following sets of confidential information:

- _____
- _____
- _____

Penalties for Non Compliance

- I have been advised of the location of and have access to the Department of Health Personnel Handbook and understand the disciplinary actions associated with a breach of confidentiality.
- I understand that a security violation may result in criminal prosecution and disciplinary action ranging from reprimand to dismissal.
- I understand my professional responsibility and the procedures to report suspected or known security breaches.

The purpose of this computer use and confidentiality agreement is to emphasize that access to all confidential information regarding a member of the workforce or held in client health records is limited and governed by federal and state laws. Information, which is confidential, includes the client's name, social security number, address, medical, social and financial data and services received. Data collection by interview, observation or review of documents must be in a setting that protects client's privacy. Information discussed by health team members must be held in strict confidence, must be limited to information related to the provision of care to the client, and must not be discussed outside the department.

Member of Workforce Signature

Date

Supervisor or Designee Signature

DH 1120, 7/05

SECTION B Information Resource Management (Initial each item, which applies)

The member of the workforce has access to computer related media

- Yes. Have each member of the workforce read and sign section B
- No. It is not necessary to complete section B

Understanding of Computer Related Crimes act, if applicable.

The Department of Health has authorized you to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department’s disciplinary standards and in addition to departmental discipline; the commission of computer crimes may result in felony criminal charges. The Florida Computer Crimes Act, Ch. 815, F.S., addresses the unauthorized modification, destruction, disclosure or taking of information resources.

I have read the above statements and by my signature acknowledge that I have read, and been given a copy of, or been advised of the location of the Computer Related Crimes Act Ch. 815, F.S. I understand that a security violation may result in criminal prosecution according to the provisions of Ch. 815, F.S., and may also result in disciplinary action against me according to Department of Health Policy.

The minimum information resource management requirements are:

- Personal passwords are not to be disclosed. There may be supplemental operating procedures that permit shared access to electronic mail for the purpose of ensuring day-to-day operations of the department.
- Information, both paper-based and electronic-based, is not to be obtained for my own or another person’s personal use.
- Department of Health data, information, and technology resources shall be used for official state business, except as allowed by the department’s policy, protocols, and procedures.
- Only approved software shall be installed on Department of Health computers (IRM Policy NO.50-7).
- Access to and use of the Internet and email from a Department of Health computer shall be limited to official state business, except as allowed by the department’s policy, protocols, and procedures.
- Copyright law prohibits the unauthorized use or duplication of software.

Member of Workforce Signature

Date

Supervisor or Designee Signature

Print Name

Date

Print Name

REFERENCE INQUIRY

NAME OF APPLICANT _____

ADDRESS OF APPLICANT _____

The above named person has made application with the Florida Department of Health-Escambia County to be a volunteer in one or more of our programs. You have been given as a reference by this person. Please answer the following questions about the applicant to the best of your ability.

How is applicant known to you? Business? Socially? Other?

If other, please explain _____

How long have you know applicant? _____ months _____ years

Is applicant, in your opinion, a person of good moral character? Yes No

Does the applicant, to your knowledge, abuse alcohol? Yes No Use illegal drugs? Yes No

Does the applicant, to your knowledge, participate in community activities? Yes No

Relate any knowledge you have of the applicant's interest in, and willingness to work with people with problems.

Comment as to applicant's character, integrity, or other information, which you feel, is related to the applicant's desirability to work in any program of the Department of Health.

Relate any knowledge you may have of any serious law violation in the applicant's background

Printed Name

Signature

If you have any questions or would like to discuss this, please contact our office at 850-595-6555

Please mail Reference Inquiry to:

Florida Department of Health-Escambia County, 1295 W. Fairfield Drive, Pensacola, FL 32501

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