





**Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?**

No  Yes. If "Yes," complete details below. Please note that conviction is not an automatic bar to placement. Each case is considered individually. Please include: Offense(s), place(s), date(s), and penalty(s):

I understand that, to protect persons 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 upon submission of this application it becomes public record.

I understand and agree that all information as it relates to persons served by the department is 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.

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

Medical Reserve Corps  
5527 Stewart Street  
Milton, Florida 32572  
Phone: 850 – 983 – 5200 ext. 2278  
Email: [Thomas.Verlaan@flhealth.gov](mailto:Thomas.Verlaan@flhealth.gov)

<i>For official use:</i>	<b>Application Review</b>
<b>Approved</b>	_____
<b>Denied</b>	_____
<b>Date &amp; Initials</b>	_____

It is unlawful for an employer to refuse or deprive any individual of 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, 2009 Apalachee Parkway, Suite 100, Tallahassee, Florida 32301-4857. DH 1474, 10/05

**Medical Reserve Corps Core Competencies Attestation**

I, \_\_\_\_\_, do hereby attest to the following:  
(print your name)

I have been provided with a copy of Florida Medical Reserve Corps Core Competencies and have read such documents.

I understand that, by holding a position within state government, I have taken on the mantle of public service.

I am committed to maintaining an honest, ethical, and open system of government for the people of Florida.

I therefore pledge to honestly and faithfully comply with both the letter and spirit of the Core Competencies, as well as the requirements set forth in Chapter 112, Part III, Florida Statutes, in the discharge of my duties and responsibilities as a public servant. As part of this commitment, I pledge to be on guard against and to avoid the appearance of impropriety in conducting the people's business.

I further pledge that, should questions regarding appropriate chain of command arise, I will seek guidance from the appropriate person within the Office of the Medical Reserve Corps or my agency on how to resolve the matter in question.

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



**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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Coordinator Signature

**Medical Reserve Corps Core Competencies and Fact Sheet**

I, [print full name] \_\_\_\_\_, hereby attest that I have received a copy of the Medical Reserve Corps Fact Sheet and Core Competencies Matrix. I understand that as a responder volunteering with the Florida Department of Health and the Medical Reserve Core, I should read and become familiar with the MRC Core Competencies.

I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date Signed

## Background Screening Requirements Attestation

I understand that my position has been designated as "sensitive" due to the trust and responsibility required, and that background screening is a condition of employment.

In accordance with the department's Background Screening Policy, DOHP 60-5-08, and Chapter 435, Florida Statutes, I attest under penalty of perjury that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to any offense listed in Section 435.04, Florida Statutes, as amended. I will notify my supervisor if I have been found guilty of, regardless of adjudication, or enter a plea of nolo contendere or guilty to, any offense listed in Section 435.04, Florida Statutes, as amended.

Additionally, I will notify my supervisor if I am arrested or convicted of any criminal offense while employed with the Department of Health.

\_\_\_\_\_  
Member of Workforce Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



## Acceptable Use and Confidentiality Agreement

All Florida Department of Health (Department) employees and contracted providers are responsible for complying with all laws, regulations, policies, and procedures as they pertain to the security and confidentiality of Department data, equipment, and facilities. Questions regarding applicable statutes, rules, policies, or procedures should be addressed to the Department's designated contact person, which will be provided to the individual prior to onboarding with the Department or execution of the contract.

Access to all confidential information created, collected, or maintained by the Department is limited and governed by federal and state laws. Confidential information may include client names, social security numbers, addresses, medical information, demographic and financial data, and services received by Department clients.

Confidential information in any format must be secured using appropriate administrative, technical, and physical safeguards. Confidential information must be limited to those with a documented "need to know", only be used for authorized purposes, and not be shared outside the Department.

The *Florida Computer Crimes Act, Chapter 815, Florida Statutes*, addresses the unauthorized modification, destruction, disclosure, or taking of information resources.

Failure to abide by the terms of this Agreement may include but are not limited to, disciplinary action ranging from reprimand to dismissal for Department employees, contract termination, and civil and criminal penalties as allowed under state or federal law.

### **A. Security and Confidentiality Supportive Data.**

- 1) Copies of applicable Department Policies, Protocols, Procedures, and local operating procedures have been provided to the Department employee or contracted provider.
- 2) Employees and contract providers have been informed of their professional responsibility and procedures on how to report suspected or known security breaches to the Department.

### **B. Minimum Information Resource Management Requirements.** The Department employee and contracted provider acknowledge the following:

- 1) Personal passwords connected to a Department email address or database are not to be disclosed. There may be supplemental operating procedures that permit shared access to email to ensure the department's day-to-day operations.
- 2) Paper-based and electronic information are not to be obtained for personal use.
- 3) Department data, information, and technology resources shall be used for official state business, except as allowed by Department policy, protocols, and procedures.
- 4) Only approved software shall be installed on Department computers.





Acceptable Use and Confidentiality Agreement

- 5) Access to and use of the internet and email from a Department computer shall be limited to official state business, except as allowed by the Department policy, protocols, and procedures.
6) Copyright law prohibits the unauthorized use or duplication of software provided to the Department employee or contracted provider to use.

By signing this Agreement, I agree to abide to all the terms and conditions outlined above and have the authority to sign this Agreement on behalf of myself or the contracted provider, as applicable.

Authorized Representative
Printed Name

Authorized Representative
Signature

Contract No. (if applicable)

Date

\*\*\*\*\*
THIS SECTION WILL BE COMPLETED BY THE DEPARTMENT
\*\*\*\*\*

Department Representative Printed Name

Department Representative Signature

Date

Contract No. (if applicable)