Santa Rosa County Medical Reserve Corps Volunteer Application

Please Print Clearly

Personal Contact Information

Name: _____
Last First Middle

Home Address: _____ City: _____ ZIP: _____

Email(s): _____

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Employer Contact Information. Includes other volunteer work or most recent previous employment.

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer: _____ Address: _____

Phone Number: _____ Your Extension: _____

Your Work Email: _____ Duration of Employment: _____

Preferred Method of Communication for Routine Matters. Please check two.

☐ Email ☐ Phone ☐ US Postal Mail

Education and Licensure

Degree/Specialty	Date Received/Expected

List All Professional Licenses	State Issued and Number	Expiration Date

Are you board certified? ☐ Yes ☐ No
Do you have prescriptive authority? ☐ Yes ☐ No
Are you retired and licensable in good standing? ☐ Yes ☐ No

I understand that my credentials/licenses will be verified. _____ (initial)

Please attach a copy of your current professional license/certification to this application.

Skills

Language Proficiency (other than English): _____

Computer and Technical: _____

Managerial and Administrative: _____

Marketing and Outreach: _____

Other: _____

Certifications and Training Completed (Include agency providing training & length of training.)

	Most Recent Date	Certifying Agency
CPR/AED:		
First Aid:		
Blood-borne Pathogens:		
Incident Command System:		
Disaster Training:		
Other:		

Volunteer Interests: Please check all that apply.

☐ Continuing Ed./Training ☐ Exercises/Drills ☐ Community Health Initiatives ☐ Disaster Response

Availability: Please check all that apply.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning (before 12pm)	☐	☐	☐	☐	☐	☐	☐
Afternoon (12-5pm)	☐	☐	☐	☐	☐	☐	☐
Evening (after 5pm)	☐	☐	☐	☐	☐	☐	☐

I prefer to be: ☐ Active (leader, recruiter, trainer, community health initiatives, etc.)
☐ Stand-by (prepared for service only in an emergency or disaster)

Are you part of an emergency/disaster plan with any other organization?
(i.e. American Red Cross, military base, hospital, etc.)

☐ Yes ☐ No If yes, please list: _____

References: Please list two people whom are unrelated to you.

_____
Name (Please Print) Phone Email

Relationship to you: _____ How long have they known you? _____

_____
Name (Please Print) Phone Email

Relationship to you: _____ How long have they known you? _____

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.

_____

Signature Date

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

For official use:	**Application Review**
Approved	_____
Denied	_____
Date & Initials	_____

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_____

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:

http://www.floridahealth.gov/preparedness-and-response/disaster-response-resources/mrc/mrc-volunteer-info.html

☐ ☐ 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:

http://www.floridahealth.gov/preparedness-and-response/disaster-response-resources/mrc/mrc-volunteer-info.html

☐ ☐ 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

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

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

Information Release for Media Purposes

Date: _____

I hereby give my informed written consent for the making of photographs, motion picture films, video tapes, and sound recordings of _____ (name) for use as part of the Florida Department of Health Santa Rosa County Health Department's public information, educational and training activities.

I authorize the Health Department to release to the public, including the news media, information regarding benefits of services the above named has received from or through the Health Department. This shall include release of name and other identifying information, as well as photographs, motion picture films, video tape or sound recordings.

It is my understanding that such material may be used by the Health Department and its agents for an indefinite period of time unless this authorization is revoked in writing. However, if revoked, the Santa Rosa County Health Department shall not be required to recall affected publications, photographs, motion pictures, slides or sound recordings then in use.

_____	_____	_____
Volunteer Signature	Date	Print name

Florida Department of Health – Santa Rosa County
5527 Stewart Street• Milton, Florida 32572-0929
Matthew Dobson, M.S, FDOH Administrator – Santa Rosa
http://www.floridahealth.gov/chdSantaRosa/index.htm
850.983.5200

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 Statues, I attest under penalty of perjury that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendre or guilty to any offense listed in Section 435.04, Florida Statues, as amended. I will notify my supervisor if I have been found guilty of, regardless of adjudication, or enter a plea of nolo contendre or guilty to, any offense listed in Section 435.04, Florida Statues, 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