Dear Volunteer:

Thank you for your interest in the Florida Department of Health in Pinellas County's Volunteer Services Program.

Attached is a volunteer packet. Please fill it out and return to Volunteer Services Program by mail, fax or bring to the office at the following address:

Alle Ream, Volunteer Services Program
Florida Department of Health in Pinellas
8751 Ulmerton Rd. Largo, Fl. 33771
Phone: 727-275-6358
Fax: 727-507-4333

Personal References
Two personal references from two individuals not related to you are required. For your convenience, there are two reference forms in the packet.

Licensed Health Care Professionals
Please include a copy of your medical license.

When I receive your completed packet, you will be contacted. Thank you for wanting to make a difference in Pinellas County.

If you have any questions or need assistance with the forms, please feel free to contact Volunteer Services at 727-275-6358.

Sincerely,

Alle Ream

Volunteer Services Program Coordinator

Florida HEALTH

VOLUNTEER ENROLLMENT APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Home Telephone / Cell phone / Fax #

Email: _____ _____
Emergency Contact Telephone Number

What type of volunteer position are you interested in? _____

List any professional license, registration, or certificate you currently possess (include certificate/license number): _____

List any special skills, interests, or hobbies: _____

List any special considerations or needs: _____

List two personal references not related to you whom you have known for more than one year:

NAME	NAME
ADDRESS	ADDRESS
CITY/STATE ZIP	CITY/STATE ZIP
PHONE	PHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

TITLE DATES OF VOLUNTEER/EMPLOYMENT JOB

Specify the days and time frames you are available to volunteer: _____

Day of Week	Hours	Day of Week	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Have you ever been convicted of or pled nolo contendere to a driving or criminal offense?
Yes _____ No _____ if answer is yes, please explain (including types of offenses and dates):

_____

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

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

INTERVIEWER'S COMMENTS
(For Agency Use Only)

Date of Interview: ___/___/_____ **Interviewer's Name:** _____

_____

_____

Screening Required: Yes _____ **No** _____ **Date Screening Completed:** _____

Date Orientation Completed: _____

WORK ASSIGNMENT
(For Agency Use Only)

_____ _____
Program **Location**

_____ _____
Supervisor **Date of Placement**

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.

Florida HEALTH

VOLUNTEER RECORD CHECK

I, hereby grant _____
Print Full Name: First Middle Last (Maiden, if applicable)

permission to the Department of Health to obtain information from local and state law enforcement agencies to help determine my suitability to serve as a Department of Health volunteer. I understand that if the records check shows any violations committed or other information about my background that would indicate unsuitability or a risk; I may not be accepted into the Department of Health Volunteer Program.

_____ _____
Social Security Number Date of Birth

_____
Race/Sex

_____
Complete Address City State Zip

_____ _____
Signature Date

FLORIDA
DEPARTMENT OF HEALTH
IN PINELLAS COUNTY
VOLUNTEER SERVICES
MEMORANDUM OF UNDERSTANDING
REGARDING CONFIDENTIALITY OF CLIENT INFORMATION

The purpose of this memorandum of understanding is to emphasize that all information held in health records is confidential, with access governed by state and federal laws. Information that is confidential includes the client's name, address, medical, social and financial data and services received. Data collection by interview, observation or review of documents should be in a setting, which protects the client from unauthorized individuals. Information discussed by health team members at conferences or team meetings must be held in strict confidence, Client health information should not be discussed outside the agency.

Chapter 384.29 F.S., addresses the need for special discretion in the handling of sexually transmitted diseases, by their nature involve sensitive issues of privacy and all programs designed to deal with these diseases should afford clients privacy, confidentiality and dignity.

I have read Chapter 384.29, F.S. I understand and agree to provide by the provision of this memorandum.

384.29 Confidentiality.--

(1) All information and records held by the department or its authorized representatives relating to known or suspected cases of sexually transmissible diseases are strictly confidential and exempt from the provisions of s. 119.07(1). Such information shall not be released or made public by the department or its authorized representatives, or by a court or parties to a lawsuit upon revelation by subpoena, except under the following circumstances: (a) When made with the consent of all persons to which the information applies; (b) When made for statistical purposes, and medical or epidemiologic information is summarized so that no person can be identified and no names are revealed; (c) When made to medical personnel, appropriate state agencies, public health agencies, or courts of appropriate jurisdiction, to enforce the provisions of this chapter or s. 775.0877 and related rules; (d) When made in a medical emergency, but only to the extent necessary to protect the health or life of a named party, or an injured officer, firefighter, paramedic, or emergency medical technician, as provided in [1]s. 796.08(6); or (e) when made to the proper authorities as required by chapter 39 or chapter 415. (2) When disclosure is made pursuant to a subpoena, the court shall seal such information from further disclosure, except as deemed necessary by the court to reach a decision, unless otherwise agreed to by all parties. Except as provided in this section, such information that is disclosed pursuant to a subpoena is confidential and exempt from the provisions of s. 119.07(1). (3) No employee of the department or its authorized representatives shall be examined in a civil, criminal, special, or other proceeding as to the existence or contents of pertinent records of a person examined or treated for a sexually transmissible disease by the department or its authorized representatives, or of the existence or contents of such reports received from a private physician or private health facility, without the consent of the person examined and treated for such diseases, except in proceedings under ss. 384.27 and 384.28 or involving offenders pursuant to s. 775.0877. **History.**--s. 90, ch. 86-220; s. 5, ch. 90-292; s. 7, ch. 90-344; s. 11, ch. 93-227; s. 17, ch. 96-322; s. 199, ch. 96-406; s. 138, ch. 98-403.

[1]**Note.**--Repealed by s. 2, ch. 94-205.

Volunteer Signature	Supervisor Signature
Date	Date

VOLUNTEER CHECK LIST

Volunteer Name: _____ Title: _____

Supervisor: _____Location: _____

Two Personal References: (1) _____ (2) _____

Code of Ethics: _____

Client Confidentiality: _____

Application: _____ Received date: _____

Records check form: _____

CJIS Completed: _____

MQA Completed: _____

Fingerprints Completed: _____

ID Badge Completed: _____

Professional License #:_____Expiration Date: _____

Protocols Required for ARNP's (& a copy of their Curriculum Vitae): __

Notes:

_____

_____

_____

_____

_____

_____

ENTERED INTO ACTIVE LIST: _____ ***(excel list & tracking database)***

When the Volunteer is approved: Send the Volunteer a Welcome Letter, then Send to Supervisor a packet including, a copy welcome letter, Time Sheet, Vol. Check List Mandatory training, Training instructions sheet, & Termination Sheet.

Completed by Supervisor:

Position Description: _____

CAP Form (DOH Volunteer only):_____

Acceptable Use and Confidentiality Agreement (DOH1120) _____

FDOH Information Security and Privacy Awareness: _____

Two Personal Reference Forms are required to be filled out by two people you know (but who are not related to you).

Florida HEALTH

Volunteer Personal Reference Questionnaire

_____ _____

Name of Volunteer/Intern Applicant Date Completed

As required by section 110.503, Florida Statutes and section 60L-33.006, Florida Administrative Code, reference checks must be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Department of Health. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

1. How long have you known the volunteer applicant? _____
2. To your knowledge, has the applicant ever been convicted of a crime? _____
3. Do you consider him/her to be of good moral character? If no, please explain. _____
   _____
4. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____
   _____
5. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____
6. Do you have any additional comments concerning the applicant's character or reliability? ____
   _____
7. What is your relationship to the applicant? _____

_____ _____

Reference Signature Name (please print)

_____ _____

Address Telephone

_____

City State Zip

Thank you for your time.

Upon completion, please return this form to: The volunteer

Two Personal Reference Forms are required to be filled out by two people you know (but who are not related to you).

Florida HEALTH

Volunteer Personal Reference Questionnaire

Name of Volunteer/Intern Applicant _____ Date Completed _____

As required by section 110.503, Florida Statutes and section 60L-33.006, Florida Administrative Code, reference checks must be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Department of Health. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

4. How long have you known the volunteer applicant? _____

5. To your knowledge, has the applicant ever been convicted of a crime? _____

6. Do you consider him/her to be of good moral character? If no, please explain. _____
_____

8. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____
_____

9. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____

10. Do you have any additional comments concerning the applicant's character or reliability? ____
_____

11. What is your relationship to the applicant? _____

_____ _____
Reference Signature Name (please print)

_____ _____
Address Telephone

_____
City State Zip

Thank you for your time.

Upon completion, please return this form to: The volunteer

FLORIDA
DEPARTMENT OF HEALTH
IN PINELLAS COUNTY
VOLUNTEER SERVICES
CODE OF ETHICS

DOH 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 clients.

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 service center specialist.

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 DOH 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	Supervisor Signature
_____	_____
Date	Date