ACKNOWLEDGMENT OF RESPONSIBILITY

TO MAINTAIN CONFIDENTIALITY OF MEDICAL INFORMATION

By virtue of your employment or volunteer capacity with the Florida Department of Corrections, you may need to know and, therefore, may be informed of certain medical/mental health information pertaining to individual inmates necessary to perform your assigned duties and/or to classify and transfer inmates to facilities appropriate for delivery of the required health care services for diagnosed medical/mental health conditions.

State law, and in some instances, federal law, mandates that medical/mental health information be kept confidential unless specific written authorization is given by the patient or unless compelled by court order or subpoena when certain conditions are met for release of the medical/mental health information.

By signing this form, you acknowledge that you must maintain as confidential all medical/mental health information regarding any inmate which you obtain in conjunction with your duties and responsibilities and you further acknowledge that you may not disseminate this medical/mental health information to or discuss the medical/mental health condition of an inmate with any person except those persons directly necessary to the performance of your duties and responsibilities. If you have been designated as a member of the department's Healthcare Transfer Team, you may not disseminate inmate medical information to or discuss the medical condition of an inmate with any person except other members of the Healthcare Transfer Team, medical staff, upper level management at the institutional/facility level, regional level, and central office level, or department attorneys. The dissemination or discussion of inmate medical information with the team members or persons enumerated herein shall only be to the extent necessary for the provision of health care to the inmate; the health and safety of others; law enforcement purposes; the administration and maintenance of safety, security and good order of the institution; and other purposes as authorized by law.

Breach of this confidentiality may result in monetary liability and/or civil or criminal penalties imposed by law, and shall subject you to discipline, up to and including dismissal, for violation of department rules.

_____	_____
Signature of Employee/Volunteer	Employee's/Volunteer's Printed Name
_____	_____
Date	Social Security Number

DC2-813 (Revised 2/06)

DEPARTMENT OF CORRECTIONS
CITIZEN VOLUNTEER JOB DESCRIPTION

JOB TITLE: CITIZEN VOLUNTEER: _____
(example: Worship Leader, Study Leader, Mentor, etc.)

Facility: _____ Department: _____

Frequency and Hours:

_____ Weekly _____ Monthly _____ Other: _____ Service Hours: _____

RESPONSIBILITIES:

1) Provide supervision of inmates/offenders assigned to their activity and ensure compliance with all Department rules and regulations.
2) Coordinate their activities with the supervisor and/or the staff.
3) Inform their supervisor and/or staff of any information or activity that may be a threat to the security of the institution or safety of any individual.
4) Other: (specify)

_____
_____
_____

5) Other: (specify)

_____
_____
_____

Job Related Skills, Education, Certification or Licensure:

_____
_____
_____

_____
Signature of Volunteer Date

Comments:

_____
_____
_____

_____
Supervisor Date

DC5-611 3/03

To Contact !
E-mail: hni@aasrq.org
Phone: (941)-444-9698

FLORIDA DEPARTMENT OF CORRECTIONS
VOLUNTEER APPLICATION

Personal Information

Name: _____ _____ _____ _____
Last First Middle Maiden

Address: _____ _____ _____ _____
City State ZIP Code

_____ _____ _____
Telephone #1 Telephone #2 E-Mail Address

Volunteer Group Name: _____

Security Clearance Information

Social Security #: _____ Date of Birth: _____

Race/Ethnic Origin: _____ Gender: ☐ Male ☐ Female

Drivers License #: _____ DL State: _____

1. Have you ever been arrested on a misdemeanor or felony charge? ☐ Yes ☐ No
   If yes, explain. (Use additional paper if necessary) _____

2. Have you ever been convicted on a misdemeanor or felony charge? ☐ Yes ☐ No
   If yes, explain. (Use additional paper if necessary) _____

3. Do you have a relationship (for example parent, spouse, friend, etc) or are you currently on the visitation list of anyone incarcerated? ☐ Yes ☐ No
   If yes, give the inmate's name, DC#, and your relationship to the inmate.
   Name: _____ DC#: _____ Relationship: _____

4. Have you ever worked for the Florida Department of Corrections? ☐ Yes ☐ No
   If yes, please indicáte where and when you were employed. _____

5. Do you have any relatives working for the Department of Corrections? ☐ Yes ☐ No
   If yes, provide: Name: _____
   Relationship: _____ Work Location: _____

In case of emergency notify: _____ _____
Name (area code + number)

- Qualified applicants are considered without discrimination based upon race, color, national origin, age religious preference, or handicap.
- Intentionally falsifying or omitting information may result in disapproval of your volunteer application.

I CONFIRM THAT ALL INFORMATION IS ACCURATE AND COMPLETE.

_____ _____ _____
Signature *Printed Name* *Date*

DC5-601A (Revised 2/08)

In accordance with s. 119.071(5)(a)2, your social security number is being collected in order to complete an FCIC/NCIC security report so that you can be approved as a volunteer. The Department will not use the social security number collected for any purpose other than the purpose provided above.