

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 indicate 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

FLORIDA DEPARTMENT OF CORRECTIONS

ACKNOWLEDGEMENT OF RESPONSIBILITIES

In consideration of the opportunity to serve in the Department of Corrections as a Citizen Volunteer:

- I acknowledge that today I have been furnished with a copy of the volunteer rules.
- I understand that I am responsible for reading and complying with the rules.
- I will work in cooperation with staff.
- I will honor the civil and legal rights of all offenders/inmates.
- I will not use my official position to secure privileges or advantages for myself.
- I will report unethical behavior or rule violations to an appropriate Department supervisor.
- I will not discriminate against any offender/inmate, employee, or prospective employee on the basis of race, gender, creed, national origin, or religious preference.
- I acknowledge the drug-free workplace policy of the Department of Corrections and I know I am subject to random drug testing.
- I agree to abide by the policies and procedures regarding confidentiality of records and medical information.

WAIVER OF LIABILITY

I hereby waive all liability to the Department of Corrections and its employees, for any and all injuries which may occur to me during my term of service with the Department of Corrections. Volunteers and interns, when working for the department, are covered by Worker's Compensation in accordance with Chapter 440 of the Florida Statutes. I understand that I am the person responsible to ensure that I am in compliance with any and all applicable State Law, Department of Corrections Policy, or any Regulation which may affect me during this period.

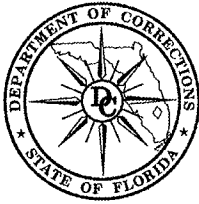
I have attended and received citizen volunteer training and have read the Acknowledgement of Responsibilities, Waiver of Liability, and agree to abide by the conditions therein.

Signature: _____ Date: _____

Pin #: _____ Person Conducting Volunteer Training: _____

Volunteer Training Date: _____ Location: _____

Regular-Services Volunteer Information Sheet



STATE OF FLORIDA
 DEPARTMENT OF CORRECTIONS
 Bureau of Programs

F.A.S.T. Pin #: _____

Name: _____

Address: _____

City State Zip

Telephone #1: _____

Telephone #2: _____

Email: _____

SS#	Hair	Eyes	Ht	Wt	DOB	Sex	Race

(This information is confidential)

Official Use:

Facility/Department: _____

Training Date: _____ **FCIC/NCIC* Date:** _____ **Hits:** Yes No

Approved: _____ **Date:** _____
 (Approving Authority[†])

* An annual background check should be done for each active regular service volunteer. The temporary volunteer badge is produced in accordance with "Identification Cards," Procedure 604.002.

† The Chaplaincy Services Administrator or institutional lead Chaplain is the approving authority when the volunteer has no previous period of incarceration or supervision. When a proposed volunteer has a previous period of incarceration or supervision, the approving authority is the Assistant Secretary for institutions or designee. ("Volunteers," Procedure 503.004).

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

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

Last 4 Digits of Social Security Number

CONFIDENTIAL

**HARDEE CORRECTIONAL INSTITUTION
FCIC/NCIC REQUEST FORM**

FIRST NAME		ORGANIZATION	
MIDDLE NAME		REASON	Volunteer
LAST NAME			
DOB		AGE	
SSN		FDLE#	
FBI#			

REQUESTED BY Dr. R. Mutcherson, Senior Chaplain DEPT CHAPEL DATE _____

APPROVED DISAPPROVED BY _____ DATE _____

YEAR	DATE	SUBMITTED BY	APPROVED	APPROVED BY	DATE

FILE CHECKLIST

- | | |
|--|---|
| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> REGULAR VOLUNTEER <input type="checkbox"/> APPLICATION DC5-610B <input type="checkbox"/> F.A.S.T. REGISTRATION <input type="checkbox"/> CITIZEN VOLUNTEER AGREEMENT <input type="checkbox"/> SIGNED ETHICAL AND CONDUCT STANDARDS INFORMATION <input type="checkbox"/> SIGNED WAIVER OF LIABILITY, WORKER'S COMPENSATION STATEMENT, CONFIDENTIALITY AGREEMENT | <ul style="list-style-type: none"> <input type="checkbox"/> APPLICATION DC5-610A <input type="checkbox"/> COMPETED BACKGROUND CHECK <input type="checkbox"/> ORIENTATION AND TRAINING <input type="checkbox"/> SIGNED JOB DESCRIPTION <input type="checkbox"/> HIPPA MEDICAL |
|--|---|