

NEIGHBORHOOD HEALTH CLINIC VOLUNTEER APPLICATION

Please print legibly and answer all questions

Name: Circle: Mr, Mrs, Ms, Miss _____ (last) (first)

Once this application is returned to the Clinic, your name will be entered into our database to receive all mailings and notices. Please add your e-mail address for additional mailings.

Local address _____ Unit # _____ (number and street)

City _____ State _____ Zip code _____

Home phone # _____ Work _____ Cell _____

E-mail address _____ Spouse's name: _____

Months I am in Naples _____

Non-local address _____ (street) (city/state) (zip)

MEDICAL VOLUNTEERS ONLY:

Licenses: LPN _____ RN _____ ARNP _____ RPh _____ Pharmacy Tech _____ Physician _____

Active FL License: Yes _____ No _____ Retired: Yes _____ No _____ If retired, how long _____

Other licenses: _____

PLEASE PROVIDE COPY

Skills, hobbies, interests: _____

Languages spoken: _____

Days / Times available:(Circle) Mon Tues Wed Thur Fri Sat Clinic ___ Office _____

I am interested in the following volunteer opportunities:

Computer _____ DR Hostess _____ Errands _____ Fund Raising/Special Events _____ General Office _____

Grant research/writing _____ Patient Interviews _____ Meal Preparation _____ Medical Support _____

Pharmacy support _____ Translating _____ Transcribing _____

Jobs I've enjoyed in the past at work or as a volunteer were: _____

I understand the importance of maintaining confidentiality and will sign the confidentiality agreement. (please initial) _____

Signature _____ Date _____



VOLUNTEER ENROLLMENT APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone / Cell Phone

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
ADDRESS
CITY/STATE ZIP
PHONE

NAME
ADDRESS
CITY/STATE ZIP
PHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

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 plead 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.



Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D., FACP
State Surgeon General

**MEMORANDUM OF UNDERSTANDING REGARDING
CONFIDENTIALITY OF CLIENT INFORMATION**

The purpose of this memorandum of understanding is to bind the signatory below to abide by all the pertinent confidentiality laws in the performance of their job or contract work with the Department of Health. It is emphasized that all information held in health records is confidential, with access governed by state and federal laws. Information which is confidential, includes the client's name, address, social security number, medical, social and financial data and services received. Data collection by interview, observation, or review of documents must be conducted in a setting which protects the client's information from unauthorized individuals. Client information must not be discussed outside the agency, except in the performance of referrals for client care.

I have read the Department of Health policies on confidentiality and understand the application of Florida Statute 384.29, of which I have been provided a copy. I understand the seriousness and importance of the confidentiality laws and agree to abide by them.

Volunteer Signature & Date

Supervisor Signature & Date

Joan M. Colfer, M.D., M.P.H., Director

3339 Tamiami Trail E ♦ Bldg. H
Naples, Florida ♦ 34112
Telephone (239) 252-8200



Mailing Address:
Post Office Box 429
Naples, Florida ♦ 34106-0429



Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D., FACP
State Surgeon General

A VOLUNTEER CODE OF ETHICS

Volunteers are subject to a code of ethics similar to that of the Health Department paid professional personnel. Volunteers are expected to do their assigned tasks and to be accountable for the quality of their work.

Volunteers make a firm commitment of their time, talents and skills for a definite period of time. They are expected to be faithful to that commitment. If you cannot report for work, you are expected to notify your supervisor and/or client.

Volunteers are expected to conduct themselves in a professional manner with dignity and courtesy at all times.

Volunteers are expected to keep strictly confidential all information they may learn directly or indirectly about a client or fellow worker. Only information on a client which is important to the performance of an assigned task should be sought out.

Volunteers are expected to bring to their work an attitude of open-mindedness and a willingness to be trained and supervised. They are expected to follow Department policies and procedures.

Each person, whether paid or unpaid brings their own unique gifts to the Department. As a whole, they enrich the department and the lives of the clients. Cooperation is expected of each person as we work together.

Volunteers are expected to attend conferences and meetings, as directed by their supervisors. They are also expected to keep simple records, such as a time sheet.

I have read this Code of Ethics and agree to abide by it.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date

Joan M. Colfer, M.D., M.P.H., Director

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Collier County Health Department

**Volunteer Services Program
BACKGROUND SCREENING DATA SHEET**

FULL NAME: _____
FIRST MIDDLE LAST

ALIAS: _____

SEX: ___ (m) ___ (f)

RACE: _____

HEIGHT: _____

WEIGHT: _____

COLOR of EYES: _____

COLOR of HAIR: _____

PLACE of BIRTH: _____
City, State or Country if other than USA

DATE of BIRTH _____
MONTH DAY YEAR

HOME ADDRESS

Include Zip Code
NOT P O BOX

CITIZENSHIP _____

SOCIAL SECURITY # _____



Acceptable Use and Confidentiality Agreement

SECTION A The Department of Health (DOH) worker and the supervisor or designee must address each item and initial.

WORKER: INDIVIDUAL SERVES IN A VOLUNTEER CAPACITY WITH THE NEIGHBORHOOD HEALTH CLINIC (NHC)/COLLIER COUNTY HEALTH DEPARTMENT

**Security and Confidentiality Supportive Data
W S**

- 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.

FLORIDA ADMINISTRATIVE CODE: <http://fac.dos.state.fl.us>

FLORIDA STATUTES: <http://www.flsenate.gov/statutes>

Position-Related Security and Confidentiality Responsibilities

I understand that the Department of Health is a unit of government and generally all its programs and related activities are referenced in Florida Statutes and Administrative Code Rules. I further understand that the listing of specific statutes and rules in this paragraph may not be comprehensive and at times those laws may be subject to amendment or repeal. Notwithstanding these facts, I understand that I am responsible for complying with the provisions of policy DOHP 50-10-10. I further understand that I have the opportunity and responsibility to inquire of my supervisor if there are statutes and rules which I do not understand.

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://fac.dos.state.fl.us> – Chapter 456.057 (confidentiality); HIPAA guidelines, Neighborhood Health Clinic Policies and Procedures

I have been given copies or been advised of the location of the following specific core DOH Policies, Protocols and Procedures that pertain to my position responsibilities:
Volunteer Code of Ethics; reporting of volunteer hours worked

I have been given copies or been advised of the location of the following specific supplemental operating procedures that pertain to my position responsibilities:
N/A

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:

- Client medical information _____
- Client identifiers (name, address, social security numbers, etc.) _____
- _____

Penalties for Non Compliance

- I have been advised of the location of and have access to the DOH Employee 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 Acceptable 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. Confidential information 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 the 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.

NHC Volunteer's Signature

Date

NHC Representative's 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. **NHC Volunteers do not have access to the DOH computer System**

Understanding of the Florida Computer 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, Chapter 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 *Florida Computer Crimes Act, Chapter 815, F.S.* I understand that a security violation may result in criminal prosecution according to the provisions of *Chapter 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 (DOHP 50-10c-10).
- 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.

NHC Volunteer's Signature

Date

NHC Representative's Signature

Print Volunteer Name

Date

Print NHC Representative Name

W=Worker/Volunteer S=Supervisor