



West Central Florida 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon (12-5pm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening (after 5pm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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
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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

West Central Florida
Medical Reserve Corps
5640 Main Street
New Port Richey, FL 34652
Phone: (727)619-0134
Email: joshua.ramirez@flhealth.gov

<i>For official use:</i>	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

HIPAA Privacy Training

Learning Objectives:

Department of Health workforce who complete this HIPAA training should be able to answer the following questions:

1. Who is covered by the HIPAA Privacy Rule?
2. What is protected health information?
3. What are the rules for use and disclosure of PHI?
4. What is the difference between using and disclosing information?
5. What is included in an authorization form?
6. When is authorization not required to disclose protected health information?
7. What is “minimum necessary”?
8. What is the privacy notice?
9. What are patient’s privacy rights?
10. What is needed to comply with HIPAA privacy requirements?

FEDERAL LAW - HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA: PRIVACY COMPLIANCE

Our health information is private. We guard it closely.

The HIPAA Privacy Rule, finalized on August 14, 2002, ensures that personal medical information you share with doctors, hospitals, and others who provide health care, and pay for it, is protected.

Basically, the HIPAA Privacy Rule does two (2) things.

It imposes new restrictions on the use and disclosure of Personal Health Information; and it gives patients greater access to, and protection of, their medical records – and more control over how they are used.

Much of the rule is not new. Health Care Providers like you have been practicing many of the privacy rules all along. HIPAA is just mandating us to convert these practices into policies and procedures that are consistent across the country.

In the next few minutes, we’ll walk through some of the basics of the final HIPAA Privacy Rule – the first comprehensive federal protection guidelines for the privacy of health information ever.

WHO IS COVERED BY THE HIPAA PRIVACY RULE?

If you are a **Health Care Provider, health plan, or a health care clearing house, that transmits health care information in electronic form**, you are covered by the HIPAA Privacy Rule. That makes you what is termed a **“covered entity”**.

Business associates such as billing services who have access to medical records are also covered indirectly by the privacy rule. We’ll get to that in a few minutes.

First, let us look at what health information is protected.

WHAT IS PROTECTED HEALTH INFORMATION?

When a patient gives personal health information to a covered entity like you, that information becomes **protected health information, or more simply, “PHI”**.

PHI includes any health information and other patient information that is used or disclosed by a covered entity in any form, oral or recorded, on paper or sent electronically.

If it's protected health information, it also contains personal information that connects the patient to the information.

For example, the individual's name, address, social security or other identification numbers, physician's personal notes, billing information, or any other information that connects the patient to the information.

Now that you know who and what is protected, let us take a closer look at some of the Requirement basics.

WHAT ARE THE RULES FOR USE AND DISCLOSURE OF PHI?

HIPAA's Privacy Rule is all about the use and disclosure of protected health information, or PHI.

PHI is **used** when it is shared, examined, applied, or analyzed by a covered entity.

PHI is **disclosed** when it is released, transferred, or in any way accessed by anyone outside that covered entity.

With few **exceptions**, protected health information cannot be used or disclosed to anyone unless it is **permitted** or **required** by the privacy rule.

You are **permitted** to use or disclose **PHI for treatment, payment and healthcare operations (TPO)**; with authorization or agreement from the individual patient or for disclosure to the individual patient; for uses that are incidental, such as waiting room sign-in sheets or physicians talking to patients in semi-private rooms or conferring at nurse's stations without fear of being overheard by a passerby; or transfer of records upon sale of, or merger of, a covered entity.

You are **required** to use or disclose PHI when **requested or authorized by the individual (although some exceptions apply) and when required by the Department of Health and Human Services (DHHS) for investigation or compliance.**

WHEN IS AUTHORIZATION REQUIRED?

The final ruling makes consent for routine health care optional, but authorization rules stand. As health care providers you know about authorizations – you have been getting them for years. The privacy rule is just requiring that you get them **in writing** so nothing falls through the cracks.

In simple terms, PHI cannot be used or disclosed for purposes other than treatment, payment or health care operations without authorization from the patient.

Written authorization is required for use or disclosure of psychotherapy notes (except for treatment, payment or health care operations) for use and disclosure to third parties for marketing activities such as selling lists of patients and enrollees. However, health care providers and other covered entities can communicate freely with patients about specific treatment options and other health related information including disease management.

For example, health care plans can inform patients about additional coverage and services such as discounts for prescription drugs.

WHAT IS INCLUDED IN AN AUTHORIZATION FORM?

The privacy rule outlines the specifics of what should be included in your authorization form.

- **A description of the PHI to be used or disclosed in clear, understandable language.**
- **Who will use or disclose the PHI and for what purpose.**

- **Whether or not use or disclosure will result in financial gain for the covered entity.**
- **The patient's right to revoke authorization.**
- **A signature of the patient whose records are being used or disclosed.**
- **Date of signing**

But keep in mind that each authorization form only covers the use and disclosure outlined in that form, and it has an **expiration date**. After that, you are required to get a new authorization.

WHEN IS AUTHORIZATION NOT REQUIRED?

In some limited circumstances the privacy rule permits the use and disclosure of PHI without authorization but with patient agreement. For instance, to maintain a facility patient directory; or inform family members or other identified persons involved in the patient's care or payment; or notify them on patient location, general condition, or death; and, to inform appropriate agencies during disaster relief efforts.

Other permitted uses and disclosures that do not require patient agreement include public health activities related to disease prevention or control; to report victims of abuse, neglect, or domestic violence; health oversight activities such as audits, administrative or legal investigations; licensure; or for certain law enforcement purposes or government functions; for coroners, medical examiners, funeral directors, tissue or organ donations, or certain research purposes; to avert a serious threat to health and safety.

PHI can also be used or disclosed for research, public health or healthcare operations as a Limited Data Set. This means any data that could possibly link the PHI to a person has first been removed.

WHAT IS MINIMUM NECESSARY?

In general, **disclosure of PHI is limited to the minimum amount of health information necessary to get the job done**. That means covered entities have to develop policies and practices to make sure the least amount of health information is shared both inside and outside of your facility. Also, employees who regularly access PHI must be identified, along with the types of PHI needed and the conditions for access.

Health Care Providers can discuss a patient's treatment with other professionals without violating the rule if they take **reasonable safeguards** to avoid being overheard.

The minimum necessary rule does not apply to the use and disclosure of medical records for treatment for obvious reasons. Health Care Providers need access to the entire record to provide quality care.

WHAT IS THE PRIVACY NOTICE?

The HIPAA Privacy Rule gives patients the right to adequate notice concerning use and disclosure of their PHI, as well as patients' rights and the covered entity's legal duties.

Adequate notice must be given on the first date of service delivery or as soon as possible after an emergency. Also, covered entities must make an effort to get written acknowledgement of receipt of notice from patients and keep copies of all notices and acknowledgements or document reasons why it was not obtained. Also, notice of your facility's privacy practices should be made available to patients in print, displayed at the site of services, and when possible, posted on a web site. New notices must be issued when your facility's privacy practices change.

WHAT ARE PATIENT'S PRIVACY RIGHTS?

The privacy rule grants patients new rights over their health information. As a covered entity, it is your job to make sure patients can exercise these rights over the PHI that you maintain.

They include the right to:

- Receive privacy notice at time of first delivery of services.
- Restrict use and disclosure although the covered entity is not required to agree.
- Have PHI communicated to them by alternate means and at alternative locations to protect confidentiality.
- Inspect, amend or correct PHI and obtain copies with some exceptions.
- **Request a history of non-routine disclosures** for six (6) years prior to the request.
- Finally, patients have a right to contact designated persons regarding any privacy concern or breach of privacy both within the facility and at DHHS.

WHAT ABOUT THE PRIVACY RIGHTS OF MINORS?

For the most part, **parents have right to access and control the PHI of their minor children, except in situations when state law overrides parental control. Examples include HIV testing of minors without parental permission, or in cases of abuse, or when parents have agreed to give up control of their minor child.**

WHAT MUST ADMINISTRATION DO TO COMPLY?

We have covered most of the basics. Now let us move on to some of the things your facility will need to comply with concerning the privacy portion of HIPAA.

- Allow patients to see and copy their PHI.
- Develop a notice of privacy practices document.
- Develop policies and safeguards to protect PHI and limit incidental use or disclosure.
- Institute employee training programs so everyone knows about the privacy policies and procedures for safeguarding PHI.
- Institute a complaints process and file and resolve formal complaints.
- Make sure contracts with business associates comply with the privacy rule.

The privacy rule also **requires a designated full or part time privacy official responsible for implementing the programs, and a contact person or office responsible for receiving complaints.** It is a good idea to get to know your facility privacy officer so you can go to him or her with any issues you do not understand.

WHAT HAPPENS TO THOSE WHO DO NOT COMPLY?

HIPAA established civil and criminal penalties for violations of the privacy rule. For starters, there is a \$100 civil penalty up to a maximum of \$25,000 per year **for each standard violated**; and a criminal penalty for knowingly disclosing PHI, a penalty that may escalate to a maximum of \$250,000 for conspicuously bad offenses.

But keep in mind that the DHHS is mandated to give you and your organization advice, technical assistance, and help you work out problems if you inadvertently make a mistake.

WHAT CAN YOU DO TO PROTECT PATIENTS PRIVACY AND CONFIDENTIALITY?

It looks like a lot to understand, but the privacy rule is not going away, and for a very good reason – it protects our fundamental right to privacy and confidentiality. That means **HIPAA's Privacy Rule is everyone's business – from the CEO to the health care professional to the maintenance staff.**

So, do your part by making sure you understand the privacy practices fully and protect your patients' personal health information, **and encourage others to do the same.**

HIPAA Privacy Quiz

1. True False The HIPAA Privacy Rule protects a patient's fundamental rights to privacy and confidentiality.
2. True False You are called a covered entity if you are a healthcare provider, health plan, and healthcare clearinghouse who transmits health information in electronic form.
3. True False Protected Health Information is anything that connects a patient to his or her health information.
4. True False PHI includes all health information that is used/disclosed – except PHI in oral form.
5. True False PHI is used when it is shared, examined, applied or analyzed.
6. True False PHI is disclosed when it is released, transferred, or allowed to be accessed or divulged outside the covered entity.
7. True False You are permitted to use/disclose PHI for treatment, payment, and healthcare operations.
8. True False You are required to use/disclose PHI when authorized or requested by the individual patient.
9. True False Using PHI for purpose not specified by the rules requires covered entities to get patient authorization.
10. True False Authorization must be obtained for any use/disclosure of PHI for marketing purposes.
11. True False An Authorization must contain an expiration date.
12. True False After signing an authorization, the patient can decide to revoke it.
13. True False You must obtain patient agreement to use/disclose PHI for public health activities related to disease prevention.
14. True False You can use/disclose PHI without patient agreement to report victims of abuse, neglect or domestic violence.
15. True False In general, disclosure of PHI must be limited to the least amount needed to get the job done right.
16. True False The Notice of Privacy Practices gives patients notice about the use/disclosure of their PHI, as well as their rights in general.
17. True False The Privacy Rules gives patients the right to request a history of routine disclosures.
18. True False The Privacy Rule gives patients the right to take action if their privacy is violated.
19. True False If you need help understanding the rules, the Department of Health and Human Services is required to give you assistance.
20. True False To protect patient confidentiality, learn about your facility's patient privacy rights, and encourage others to do the same.
21. True False Use of PHI is allowable for reasons of treatment, payment or operations (TPO).

Please Print the Following Information

VOLUNTEER NAME: _____ 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
June 2017

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 Pasco 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 Pasco 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

Michael J. Napier
MS, Health Officer, Administrator
Pasco County Health Department
10841 Little Road
New Port Richey, Florida 34654
<http://pasco.floridahealth.gov>
(727) 619-0152

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