



SMRT Application Checklist

STATE MEDICAL ASSISTANCE TEAM MEMBER APPLICATION PACKAGE

- ☐ SMRT Application Checklist
- ☐ SMRT Member Information Form
- ☐ State of FL Employment Application (6 pgs)
- ☐ IRS W-4 (Employee's Withholding Allowance Certificate)
- ☐ DHS Employee Eligibility Verification Form I-9 (4 pgs) **and** copies of:
 - Valid Driver License
 - Social Security Card
 - Passport (optional)
- ☐ State of FL Employee Acknowledgement (4 pgs)
- ☐ State of FL Oath of Loyalty
- ☐ Cover page of Volunteer Application
- ☐ DOH Volunteer Enrollment Application (2 pgs)
- ☐ DOH Volunteer Reference(s) (2 pgs)
- ☐ DOH Volunteer Records Check
- ☐ DOH Fingerprint Attachment
- ☐ Attach DHS/FEMA/EMI Certificate of Completion for each of the following:
(<https://training.fema.gov/is/nims.aspx>)
 - IS-100.b Introduction to Incident Command System, ICS-100
 - IS-200.b ICS for Single Resources and Initial Action Incidents
 - IS-700.a National Incident Management System (NIMS) An Introduction
 - IS-800.b National Response Framework, An Introduction
- ☐ **Current and Legible Copies** (as applicable) of:
 - Professional License(s) (i.e. RN, MD, EMT, etc. and/or non-medical)
 - Certification(s) (i.e. CPR, ACLS, etc. and/or forklift operator, CDL, etc.)
 - Immunization Records
- ☐ Complete the attached HIPPA Quiz

Please send this form to your servicing HR office as soon as possible:

RegionOne SMRT
548 Mary Esther Cutoff
PMB 339
Fort Walton Beach, FL 32548-4064
Office 850-863-3628
FAX 850-315-0289
www.floridaonedmat.org



State Medical Response Team Member Information

1. Team Name:

2. Name (Last, First, Middle, Suffix):

3. Sex

Male

Female

4. Home Address:

5. City

6. County

7. State

8. Zip

9. Social Security Number:

10. Date of Birth:

11. Home Phone:

12. Cell Phone:

13. Work Phone & Ext:

14. Work Fax:

15. Email Address:

Emergency Contact

16. Emergency Contact Name:

17. Relationship:

18. Phone 1 #:

19. Phone 2 #:

20. Emergency Contact Name:

21. Relationship:

22. Phone 1 #:

23. Phone 2 #:

24. Blood Type:

25. Religion:

Travel

26. Do you have a Passport?

yes

no

27. If Yes, Provide a Passport# _____

28. Exp. _____ 29. Issuing Country: _____

30. Do you have a valid Drivers' License?

yes

no

31. If Yes, Please provide License #: _____ 32. State: _____

33. Expiration Date: _____ 34. If applicable provide Class: _____ 35. Endorsement Code: _____

Training

36. Do you have one or more medical specialties?

yes

no

37. (If yes please list all specialties and indicate if you are Board Certified, Board Eligible, or Neither)

38. Do you have Hazmat Training?

yes

no

39. (If yes, Check training level)

Awareness

Operations

Technician

Specialist

Incident Command

Employment with the State of Florida

The State is a major employer in Florida offering many challenging and rewarding career opportunities. Included among the many advantages of working for the State are the diverse and interesting job opportunities as well as competitive salaries, benefits, and career mobility.

Most state jobs are in the **Career Service** personnel system. The Career Service system provides uniform pay, job classification, benefits, and recruitment for the majority of non-management jobs within state agencies. Career Service employees can move between agencies without any loss of state benefits.

Non-Career Service jobs include upper management and policy-making jobs in the Senior Management Service (SMS), middle management and professional positions such as physicians, attorneys, bureau chiefs in the Selected Exempt Service (SES), and temporary jobs funded by Other Personal Services (OPS). OPS employees receive an hourly wage but no benefits such as insurance, leave, or retirement.

Non-Career Service agencies are agencies in which all positions are not a part of the Career Service system and their employment procedures may differ. For example, in most cases, they may require different applications and their job titles and salaries may not be comparable to the Career Service system.



applications, and making hiring decisions. Generally, agencies accept job applications for **advertised vacancies** only. In some instances, however, agencies may accept applications on a continuous basis to meet Affirmative Action goals and for hard-to-fill vacancies. You may obtain applications from any

Career Service agency personnel office or any Florida Jobs and Benefits Center (formerly Job Service of Florida). A legible original or photocopy of the State of Florida employment application is normally required for each job vacancy for which you apply. It is also possible to obtain an application form and to apply electronically via the Internet for many vacancies at:

<http://jobsdirect.state.fl.us>

LOCATING VACANT POSITIONS

There are several ways for you to obtain state job vacancy information:

- Vacancy information is available on the Internet at: <http://jobsdirect.state.fl.us>.
- Contact individual Career Service agencies directly for information regarding their employment opportunities.
- Contact a Florida Jobs and Benefits Center for job vacancy information for all Career Service agencies, including jobs in the Selected Exempt and Senior Management Services. Check your telephone directory under "Florida Jobs and Benefits Center" or "Job Service of Florida" to locate the office nearest you.

Since agencies are not required to advertise **OPS** temporary jobs, you may wish to contact any of the state agencies for **OPS** employment consideration.

JOB SEARCH TIPS

Market yourself. Prior to completing the application, gather specific information relating to the position you seek by reviewing the job opportunity announcement or by contacting the employing agency for a description of duties and relevant knowledge, skills, and abilities. Use this information to assist you in preparing your application, cover letters, resumes and other support materials.

COMPETING IN THE SELECTION PROCESS

The first step an employing agency takes in the selection process is to review the applications which have been received to determine who is eligible to compete further in the selection process. The agency then uses job-related criteria to determine those applicants who will be asked to participate in additional assessment steps such as an oral interview, a work sample exercise, or a proficiency test. The job-related information gained during the selection process will assist the hiring official in making the final selection decision. Veterans' preference and Affirmative Action goals are also considered by the agency in the decision-making process.

If, because of a disability, you require a special accommodation to participate in the application and selection process, please notify the hiring authority in advance.

EMPLOYMENT PROCESS

Individual state agencies are responsible for announcing their job vacancies, accepting



State of Florida

EMPLOYMENT APPLICATION

Equal Opportunity Employer/Affirmative Action Employer

The State of Florida does not tolerate violence in the workplace.

Where to Find Vacancy Information:

- On the Internet: <http://jobsdirect.state.fl.us>
- Jobs and Benefits Centers - Consult your local telephone directory
- State Agency Personnel Offices

FOR OFFICIAL USE ONLY

Agency Authorized Signature

Date

Class Code

Status

POSITION APPLIED FOR

Agency: _____

Title: _____

Position Number: _____ Date Available: _____

Counties of Interest: _____

Minimum Acceptable Salary: _____

GENERAL INSTRUCTIONS

- Type or print in ink this application in its entirety.
- Specify the position for which you are applying. (Note: A **separate** application must be submitted for each vacancy. Photocopies are acceptable.)
- Submit your application to the office announcing the vacancy no later than the close of business on the announced deadline date.
- Sign your name in the Certification Section (page 4). All information you submit is subject to verification.
- Notify the agency's hiring authority in advance if you require special disability accommodations to participate in the employment process.

HOW DO WE CONTACT YOU?

Your Name

Social Security Number

Your Mailing Address

City

County

State

Zip Code

Home Phone

Business Phone

SUNCOM (State Employees)

E-mail Address

EDUCATION

HIGH SCHOOL:

NAME / LOCATION OF SCHOOL

RECEIVED:

☐

Diploma

☐

Other (specify) _____

☐

None

YOUR NAME, IF DIFFERENT WHILE ATTENDING SCHOOL: _____

COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL: (TRANSCRIPTS MAY BE REQUIRED)

NAME OF SCHOOL	LOCATION	DATES OF ATTENDANCE (MONTH / YEAR)		CREDIT HOURS EARNED		MAJOR / MINOR COURSE OF STUDY	TYPE OF DEGREE EARNED
		FROM	TO	QTR	SEM		

YOUR NAME, IF DIFFERENT WHILE ATTENDING SCHOOL: _____

JOB-RELATED TRAINING OR COURSE WORK: (VOCATIONAL, TRADE, GOVERNMENTAL, BUSINESS, ARMED FORCES, ETC.)

NAME OF SCHOOL	LOCATION	DATES OF ATTENDANCE (MONTH/YEAR)		CREDIT HOURS EARNED		COURSE OF STUDY	TRAINING COMPLETED?	
		FROM	TO	CLASS	CLOCK		YES	NO

YOUR NAME, IF DIFFERENT WHILE ATTENDING SCHOOL: _____

LICENSURE, REGISTRATION, CERTIFICATION EXAMPLES: Driver License, Teacher Certification, RN, LPN, PE, CPA, etc.

LICENSE, REGISTRATION OR CERTIFICATION:	Number	Date Received	Expiration Date	State Licensing Agency

PERIODS OF EMPLOYMENT

Describe all work experience in detail, beginning with your current or most recent job. Include military service (indicate rank), internships and job-related volunteer work, if applicable. Indicate number of employees supervised. Use a separate block to describe each position or gap in employment. If needed, attach additional sheets, using the same format as on the application. All information in this section must be completed. Resumes may be attached to provide additional information.

1 Name of Present or Last Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

2 Name of Next Previous Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

3 Name of Next Previous Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

4 Name of Next Previous Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

5 Name of Next Previous Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

6 Name of Next Previous Employer: _____

Address: _____ Your Job Title: _____

Supervisor's Name: _____ Phone No.: (____) _____

FROM: ____/____/____ TO: ____/____/____ HOURS PER WEEK: ____ (____)
MONTH DAY YEAR MONTH DAY YEAR YOUR NAME IF DIFFERENT DURING EMPLOYMENT

Duties and Responsibilities: _____

Reason For Leaving: _____

If needed, attach additional sheets, using the same format as on the application. Resumes may be attached to provide additional information.

KNOWLEDGE / SKILLS / ABILITIES (KSAs)

List KSAs you possess and believe relevant to the position you seek, such as operating heavy equipment, computer skills, fluency in language(s), etc.

EXEMPTION FROM PUBLIC RECORDS DISCLOSURE

ARE YOU A CURRENT OR FORMER LAW ENFORCEMENT OFFICER, OTHER COVERED EMPLOYEE**, OR THE SPOUSE OR CHILD OF ONE, WHOSE INFORMATION IS EXEMPT FROM PUBLIC RECORDS DISCLOSURE UNDER SECTION 119.071(4)(d), FLORIDA STATUTES (F.S.)?

☐ YES

☐ NO

**Other covered jobs include but are not limited to: correctional and correctional probation officers, firefighters, certain judges, assistant state attorneys, state attorneys, assistant and statewide prosecutors, personnel of the Department of Revenue or local governments whose responsibilities include revenue collection and enforcement or child support enforcement, and certain investigators in the Department of Children and Families [see§ 119.071.F.S.].

BACKGROUND INFORMATION

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A FIRST DEGREE MISDEMEANOR?

☐ YES

☐ NO

If "YES", what charges? _____

Where convicted? _____

Date of Conviction: _____

HAVE YOU EVER PLED NOLO CONTENDERE OR PLED GUILTY TO A CRIME WHICH IS A FELONY OR A FIRST DEGREE MISDEMEANOR?

☐ YES

☐ NO

If "YES", what charges? _____

Where? _____

Date: _____

HAVE YOU EVER HAD THE ADJUDICATION OF GUILT WITHHELD FOR A CRIME WHICH IS A FELONY OR A FIRST DEGREE MISDEMEANOR?

☐ YES

☐ NO

If "YES", what charges? _____

Where? _____

Date: _____

NOTE: A "YES" answer to these questions will not automatically bar you from employment. The nature, job-relatedness, severity and date of the offense in relation to the position for which you are applying are considered [see §112.011, F.S.]

CITIZENSHIP

The state of Florida hires only U.S. citizens and lawfully authorized alien workers. You will be required to provide identification and either proof of citizenship or proof of authorization to work in the U.S.

1. ARE YOU A U.S. CITIZEN?

☐ YES

☐ NO

2. IF NO, ARE YOU LEGALLY AUTHORIZED TO ACCEPT EMPLOYMENT WITH THE SPECIFIC HIRING AUTHORITY TO WHICH YOU ARE APPLYING?

☐ YES

☐ NO

RELATIVES

TO YOUR KNOWLEDGE, DO YOU HAVE ANY RELATIVES WORKING IN THIS AGENCY?

☐ YES

☐ NO

SELECTIVE SERVICE SYSTEM REGISTRATION

Section 110.1128, Florida Statutes, prohibits the employment of any person who was required to register with the Selective Service System under the U.S. Military Selective Service Act, but failed to do so. Additionally, if currently employed by the State, this law prohibits the promotion of such individuals or the subsequent re-hire, once they have separated from the State.

IF YOU ARE A MALE BORN ON OR AFTER JANUARY 1,1960, HAVE YOU REGISTERED OR DO YOU HAVE PROOF OF AN EXEMPTION FROM THIS REQUIREMENT (DOCUMENTATION MAY BE REQUIRED)?

☐ YES

☐ NO

☐ N/A

CERTIFICATION

I am aware that any omissions, falsifications, misstatements, or misrepresentations above may disqualify me for employment consideration and, if I am hired, may be grounds for termination at a later date. I understand that any information I give may be investigated as allowed by law. I consent to the release of information about my ability, employment history, and fitness for employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel staff, and other authorized employees of Florida state government for employment purposes. This consent shall continue to be effective during my employment if I am hired. I understand that applications submitted for state employment are public records. I certify that to the best of my knowledge and belief all of the statements contained herein and on any attachments are true, correct, complete, and made in good faith.

SIGNATURE: _____ DATE: _____

YOUR NAME: _____

POSITION TITLE FOR WHICH YOU ARE APPLYING: _____ POSITION NUMBER: _____

VETERANS' PREFERENCE INFORMATION: (Career Service positions only) For the purposes of appointments, retention, reinstatement and reemployment, Veterans' Preference ensures that veterans and eligible spouses of veterans are given consideration at each step of the selection process. However, preference does not guarantee that a veteran or the eligible spouse of a veteran will be the candidate selected to fill the position. Completion of the Veterans' Preference section below is made on a voluntary basis and kept confidential in accordance with the Americans with Disabilities Act. Listed below are the five Veterans' Preference categories.

1. A veteran with a service-connected disability who is eligible for or receiving compensation, disability retirement, or pension under public laws administered by the U.S. Department of Veterans' Affairs and the Department of Defense, **or**
2. The spouse of a veteran who cannot qualify for employment because of a total and permanent service-connected disability, or the spouse of a veteran missing in action, captured, or forcibly detained or interned in the line of duty by a foreign power, **or**
3. A veteran of any war who has served on active duty for one day or more during a wartime period, excluding active duty for training, and who was discharged under honorable conditions from the Armed Forces of the United States of America, **or**
4. The unremarried widow or widower of a veteran who died of a service-connected disability, **or**
5. A veteran who has served in a qualifying campaign or expedition for which a campaign badge or expeditionary medal has been authorized; including any Armed Forces Expeditionary Medal or Global War on Terrorism Expeditionary Medal.

The receipt of a campaign medal is not required, only service during a wartime period. Wartime periods are defined in §1.01, F.S. Veterans' Preference may only be given to non-state employees or current state employees applying to positions outside their current agency or political subdivision. Veterans' Preference is only available to Florida residents.

A DD214 or comparable document which serves as a certificate of release or discharge and any other required supporting documentation must be furnished at the time of application. Please FAX supporting documentation to the People First Service Center at 904/636-2627 by the closing date of the advertisement. Be sure to include the position number for which you are applying. In addition to the DD214, applicants claiming categories 1, 2, or 4 above must furnish supporting documentation in accordance with the provisions of Rule 55A-7.013, F.A.C. Under Florida law, preference in appointment shall be given first to those persons in categories 1 and 2 and then to those in categories 3, 4 and 5.

If a qualified applicant claiming Veterans' Preference for a vacant position is not selected, he/she may file a complaint with the Florida Department of Veterans' Affairs, 11351 Ulmerton Road, Largo, FL 33778. A complaint must be filed within 21 days of the applicant receiving notice of the hiring decision made by the employing agency or within 3 months of the date the application is filed with the employer if no notice is given.

VETERANS' PREFERENCE CLAIM: IF ELIGIBLE, WHICH VETERANS' PREFERENCE CATEGORY ARE YOU CLAIMING? (Please indicate number from Veterans' Preference Information section above.)

ARE YOU CURRENTLY EMPLOYED IN A CAREER SERVICE POSITION WITH THE AGENCY TO WHICH YOU ARE CURRENTLY APPLYING?

☐ YES

☐ NO

ARE YOU A RESIDENT OF THE STATE OF FLORIDA?

☐ YES

☐ NO

HAVE YOU RECEIVED A PROMOTIONAL APPOINTMENT, SUBSEQUENT TO ACTIVE MILITARY SERVICE, WITH THE AGENCY TO WHICH YOU ARE CURRENTLY APPLYING?

☐ YES

☐ NO

This section SHOULD be removed prior to the selection process.

EEO SURVEY Although the following information is not mandatory, it is requested to aid the State of Florida in its commitment to Equal Employment Opportunity, Affirmative Action and to meet federal reporting requirements. Refusal to answer will not result in adverse treatment of any applicant. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, 2009 Apalachee Parkway, Tallahassee, Florida 32301.

RACE/ ETHNICITY (Please identify both Race and Ethnicity)

Race (CHECK ONLY ONE):

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ 2 or more races

Ethnicity (CHECK ONLY ONE):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____

POSITION NUMBER: _____

POSITION TITLE FOR WHICH YOU ARE APPLYING: _____

Form W-4 (20)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 20 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____				
B	Enter "1" if: <table><tr><td>• You are single and have only one job; or</td><td rowspan="3">}</td></tr><tr><td>• You are married, have only one job, and your spouse does not work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</td></tr></table>	• You are single and have only one job; or	}	• You are married, have only one job, and your spouse does not work; or	• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	B _____
• You are single and have only one job; or	}					
• You are married, have only one job, and your spouse does not work; or						
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.						
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____				
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____				
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____				
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F _____				
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children	G _____				
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ For accuracy, complete all worksheets that apply. <table><tr><td>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.</td><td rowspan="3">}</td></tr><tr><td>• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</td></tr></table>	• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.	}	• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.	• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.	H _____
• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.	}					
• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.						
• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.						

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 20
1 Type or print your first name and middle initial. Last name		2 Your social security number		
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		
6 Additional amount, if any, you want withheld from each paycheck		6		\$
7 I claim exemption from withholding for 20 , and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7		

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature

(This form is not valid unless you sign it.) ▶

Date ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
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Deductions and Adjustments Worksheet**Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$	_____
2	Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$	2	\$	_____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$	_____
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	\$	_____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.)	5	\$	_____
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	\$	_____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$	_____
8	Divide the amount on line 7 by \$3,700 and enter the result here. Drop any fraction	8		_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9		_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10		_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$5,000 -	0	\$0 - \$8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 - 120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 - 110,000 -	12		
110,001 - 120,000 -	13		
120,001 - 135,000 -	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$65,000	\$560	\$0 - \$35,000	\$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9

OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment , but not before accepting a job offer.)				
Last Name (Family Name)		First Name (Given Name)	Middle Initial	Other Names Used (if any)
Address (Street Number and Name)		Apt. Number	City or Town	State Zip Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address		Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (See instructions)
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State Zip Code



Employer Completes Next Page



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial			B. Date of Rehire (if applicable) (mm/dd/yyyy):
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.			
Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
---	--------------------	--

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A		LIST B		LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	AND	Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.



EMPLOYEE ACKNOWLEDGEMENTS

This form is part of the required documentation for new employees to the Department of Health. Please initial and sign as directed and return the completed form to your supervisor/manager or human resource liaison.

I understand that it is my responsibility to review and understand:

- The **Employee Handbook and Discipline Policy and Standards for Disciplinary Action**, located on the Department's Intranet website, and that the information contained in this handbook is not all-inclusive; there will be periodic changes. Additional information regarding discipline may be found in Section 110.227, Florida Statutes, "Suspensions, dismissals, reductions in pay, demotions, layoffs, transfers, and grievances," and Chapter 60L-26, Florida Administrative Code, "Conduct of Employees." I also understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office.
- The department's **Code of Ethics Policy**. I also understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office.
- The department's **Sexual Harassment Policy** located on the department's intranet. Additional information may be found in Chapter 60L-26, Florida Administrative Code, "Conduct of Employees."
- The **Drug-Free Workplace Policy Statement** located in the Employee Handbook. This statement includes a list of all drugs, for which this department may test, described by brand names or common names, as applicable, as well as by chemical name. The names, addresses, and telephone numbers of employee assistance programs and local alcohol and drug rehabilitation programs are available to me by contracting the servicing human resource office. I also understand my compliance with this policy is a condition of employment.
- The **Workers' Compensation Handbook**. I have reviewed the procedure to follow in the event of an injury and understand my responsibilities under the Managed Care Program.
- The State of Florida **Payroll Schedule**. I have received a copy of the current biweekly payroll schedule and realize it is my responsibility to electronically submit my attendance and leave record in People First to my supervisor/manager no later than Friday following the close of the pay period. I also understand that failure to do so may result in not receiving a payroll warrant timely.
- The department's **Background Screening Policy**. I understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office.

Please check and initial the appropriate statement in each of the following sections:

Form I-9, Employment Eligibility Verification

I understand that I must provide documentation of my eligibility to work in the United States to my supervisor/manager or human resource liaison within 3 days after my employment. My initials represent that acceptable documents as referenced on page 9 of I-9 Form have been provided to my manager or human resource liaison.

Check box and initial here: _____

Secondary or Dual Employment

I am not presently receiving compensation from another job.

I am currently receiving compensation from another state agency.
If you are currently receiving compensation from another state agency, it will be necessary for you to complete a "Request for Approval of Dual Employment and compensation" from your human resource office before you begin your second job.
I am currently receiving compensation from a job outside of state government.

Check appropriate box if applicable and initial here: _____

Note: If your secondary job is outside the state government, you must complete a "Notice of Employment Outside of State Government" available from your human resource office

Degree-Seeking Students (FOR OPS EMPLOYEES ONLY)

Degree-seeking students may be employed for an unlimited number of hours. Please indicate here if you are a degree-seeking student and at which institution you are enrolled. It will be necessary for you to provide documentation of enrollment, either student identification or a copy of enrollment verification each semester or quarter.

No, I am not a degree-seeking student.

Yes, I am a degree-seeking student presently enrolled at _____

(Documentation is attached).

Check appropriate box if applicable and initial here: _____

Personnel Record Confidentiality

Section 119.07(3), Florida Statutes, contains an exemption from Public Records Law for the home address, home telephone number, and in most cases, the photograph, of certain employees, and their spouses and children. If you or your spouse falls into one of these categories, or if you are a child of someone who falls into these categories or if you have children residing with you whose non-custodial parent qualifies, you may qualify for this exemption.

Please check and initial the appropriate statement in each of the following sections:

No.	CATEGORY	PERSONAL INDICATOR	TREATMENT FOR 411 DIRECTORY
1.	Active or former law enforcement personnel, including correctional and correctional probation officers.	Sworn/Certified	Load for the 411 Directory Omit e-mail address, if so flagged
2.	Active or former personnel of the Department of Children and Family Services "whose duties include the investigation of abuse, neglect, exploitation, fraud, theft, or other criminal activities."	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
3.	Active or former personnel of the Department of Health "whose duties include the investigation of abuse or neglect."	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
4.	Active or former personnel of the Department of Revenue or local governments "whose responsibilities include revenue collection and enforcement or child support enforcement."	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
5.	Current or former State Attorneys, Assistant State Attorneys, Statewide Prosecutors, or Assistant Statewide Prosecutors.	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
6.	Firefighters certified in compliance with § 633.35, Florida Statutes	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
7.	Justices of the Supreme Court, district court of appeal judges, circuit court judges, and county court judges	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
8.	Current or former human resource, labor relations, or employee relations directors, assistant directors, managers, or assistant managers of any local government agency or water management district whose duties include hiring and firing employees, labor contract negotiation, administration or other personnel related duties.	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
9.	Current or former judges of the United States Courts of appeal, United States district judges and United States magistrate judges.	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
10.	Current or former code enforcement officers.	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
11.	Current or former United States attorneys and assistant United States attorneys.	Confidential Employee	Load for the 411 Directory Omit e-mail address, if so flagged
12.	All employees who give notice to their employing agency that they are the spouse or child of any person who is	Exempt Record	DO NOT LOAD

Please check and initial the appropriate statement in each of the following sections:

	exempted under §119.071(4)(d)1. Florida Statutes		
13.	Any employee who, under provisions of § 119.071, Florida Statutes and / or § 741.465, Florida Statutes, gives notice that he/she is the victim of a crime or involved in an investigation where disclosure of contact information is protected by court order or some other legally recognized means.	Protected Identity	DO NOT LOAD
14.	If an employee does not have an activated Exempt Record or Protected Identity indicator, neither their personal nor work contact information is exempt.	All Other Employees	Load for the 411 Directory Omit e-mail address, if so flagged

If any of the preceding numbered criteria applies to you and you are invoking this statute, please indicate the number or numbers that apply and initial below.

Criteria Number(s) _____ Initials: _____

If a category applies as the result of a relationship please indicate the name and relationship:
Name: _____ Relationship: _____

If this statute is not applicable to you, please check this box and initial here: _____

This is to certify that I have read and understand the information contained in or referenced in this section of the document and that I have taken appropriate action as directed, where applicable. I understand that this form will become a permanent part of my personnel file.

Employee Printed Name Employee Signature Date

Supervisor Printed Name Supervisor Signature Date



Oath of Loyalty

Oath of Loyalty - Section 876.05, Florida Statutes, requires that all state employees sign a Oath of Loyalty as a condition of employment.

STATE OF FLORIDA

COUNTY OF _____

I, _____, a citizen
Print Full Name: First Middle Last Suffix (Maiden, If applicable)

of the State of Florida and the United States of America, and being employed by, or an officer of the State of Florida, and a recipient of public funds as such employee or officer, do hereby solemnly swear or affirm that I will support the Constitution of the United States of America and of the State of Florida.

(Signature of Applicant)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____, by
(Month) (Year)
_____ who is personally known to me (OR) who has produced
(Name of Person Making Statement)
_____ as identification as proof of identity, and subscribed by me in the presence of
(Type of Identification)

(Signature of Notary Public, State of Florida)

(Print, Type or Commission Name of Notary Public)

(Official Seal)



State Medical Response Team Member/
Volunteer Program
110 Volunteer Application Checklist



Application- With signature on 2nd page



2 Completed Volunteer Personal Reference Questionnaires



Volunteer Services Job Description



Completed HIPAA Test

Return the completed documents to your Regional Coordinator on the date of training, or by mail after training. You may keep copies if you desire.

You keep a copy of the Volunteer Services Job Description and the Volunteer Time Sheet.

You cannot complete and sign the Eligibility and Referral Forms until you have been trained and a complete application packet is on file.

If you questions, contact

Ann Hill/Sherry Kruschke
RegionOne SMRT
548 Mary Esther Cutoff, PMB 339
Ft. Walton Beach, FL 32548
850-863-DMAT Phone
850-315-0289 Fax
annfl1dmat@gmail.com



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	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 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 the 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 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 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: _____

Briefed on duties and responsibilities of position. Explained Sovereign Immunity, Discussed HIPAA requirements and confidentiality. Briefed on duties and responsibilities of position. Explained requirements OPSEC, Operational Security, use of Social Media.

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

Date Orientation Completed: _____

WORK ASSIGNMENT (For Agency Use Only)

State Medical Response Team Ft. Walton Beach, Florida
Program Location

Ann Hill _____
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.



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 Coordinator in your application packet.



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 Coordinator in your application packet.



VOLUNTEER POSITION DESCRIPTION

To be completed by requesting program, facility, or CHD/CMS volunteer coordinator.

DATE: _____ SUPERVISOR: Ann Hill, Volunteer Coordinator

POSITION TITLE: State Medical Response Team Member

LOCATION OF POSITION: RegionOne SMRT Ft. Walton Beach, Florida

TIME COMMITMENT: as needed

DURATION OF POSITION: Indefinite

DUTIES: Screen patients, explain sovereign immunity, initiate referrals, insure referrals are completed properly with appropriate signatures, and dates. Maintain and file eligibility and referral forms in the patient's medical/dental records.

QUALIFICATIONS: Read, write and understand the English language. Possess the ability to relate to clients and their needs.

TRAINING: Briefed by the Regional Volunteer Health Services Coordinator on responsibilities and requirements of the position.

WILL THIS POSITION REQUIRE BACKGROUND SCREENING? YES X NO _____

Ann Hill/Sherry Kruschke
CONTACT PERSON

850-863-DMAT
TELEPHONE NUMBER

State Medical Response Team
PROGRAM/FACILITY

548 Mary Esther Cutoff, PMB 339 Ft. Walton Beach, Florida, 32548
ADDRESS CITY STATE ZIP

DH 1493, 10/05

One copy of this form remains with the application packet – keep a copy if desired



VOLUNTEER POSITION DESCRIPTION

To be completed by requesting program, facility, or CHD/CMS volunteer coordinator.

DATE: _____ SUPERVISOR: Ann Hill, Volunteer Coordinator

POSITION TITLE: State Medical Response Team Member

LOCATION OF POSITION: RegionOne SMRT Ft. Walton Beach, Florida

TIME COMMITMENT: as needed

DURATION OF POSITION: Indefinite

DUTIES: Screen patients, explain sovereign immunity, initiate referrals, insure referrals are completed properly with appropriate signatures, and dates. Maintain and file eligibility and referral forms in the patient's medical/dental records.

QUALIFICATIONS: Read, write and understand the English language. Possess the ability to relate to clients and their needs.

TRAINING: Briefed by the Regional Volunteer Health Services Coordinator on responsibilities and requirements of the position.

WILL THIS POSITION REQUIRE BACKGROUND SCREENING? YES X NO _____

Ann Hill/Sherry Kruschke
CONTACT PERSON

850-863-DMAT
TELEPHONE NUMBER

State Medical Response Team Member
PROGRAM/FACILITY

548 Mary Esther Cutoff, PMB 339 Ft. Walton Beach, Florida, 32548
ADDRESS CITY STATE ZIP

DH 1493, 10/05

One copy of this form remains with the application packet – keep a copy if desired



VOLUNTEER RECORD CHECK

I, _____, hereby grant
Print Full Name: First Middle Last Suffix (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 unsuitable or a risk. I may not be accepted into the Department of Health Volunteer Program.

Social Security Number

Race: (Check ONLY One)

- ☐ White
- ☐ Black/Afro American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ 2 or More Races

Sex: ☐ Male ☐ Female

Date of Birth

Ethnicity (Check ONLY One)

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino

Complete Address: City County State Zip

Signature

Date



FINGERPRINT ATTACHMENT FORM

ORIGINATING OFFICE INFORMATION

(Please provide name of contact person in office)

Office

Contact: _____, please copy Rick Miller (FL MRC Coordinator) Date: _____

Office

ACRONYM: _____ TELEPHONE: _____

EMPLOYEE INFORMATION:

Name: _____

Social Security Number: _____

Date of Birth: _____

Place of Birth: _____

Current Address: _____

City, State & Zip Code: _____

Sex: Male Female Race: _____ Weight: _____

Eye Color : _____ Hair Color: _____ Height: _____

DATE EMPLOYEE FINGERPRINTED: _____

POSITION INFORMATION:

(This information is needed to charge the office that required fee)

Position Number: _____ Class Code: _____

Position Title: _____ Location: _____

Paying with P-Card? Yes No OCA: _____

Flair Org Code: _____ EO: _____ Category: _____

Budget Entity: _____

Eligible for P-Card Contact with
And/or Flair Access: Yes No Vulnerable Persons: Yes No

Please send this form to your servicing HR office as soon as possible:

RegionOne SMRT
548 Mary Esther Cutoff
PMB 339
Fort Walton Beach, FL 32548-4064
Office 850-863-3628
FAX 850-315-0289
www.floridaonedmat.org

Department of Health
Central Office – Bureau of Human Resource Management
4052 Bald Cypress Way, BIN # B-03
Tallahassee, Florida 32399-1731



VOLUNTEER TIME SHEET

Quarter: _____ DOH Entity: _____

Program/Facility: **State Medical Response Team Member**

Name: _____
(Last) (First) (Middle Initial)

DATE	TIME IN	TIME OUT	TOTAL HOURS		DATE	TIME IN	TIME OUT	TOTAL HOURS

TOTAL NUMBERS OF HOURS WORKED: _____

SUPERVISOR'S SIGNATURE: _____

SUPERVISOR'S NAME PRINTED: _____

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 health-Care 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:** _____
AGENCY: _____ **State Medical Response Team Member**

RETURN THIS COMPLETED TEST TO YOUR VOLUNTEER COORDINATOR IN YOU APPLICATION PACKET



HIPAA: PRIVACY COMPLIANCE

Answers to HIPAA Quiz

1. True
2. True
3. True
4. False – PHI includes all health or patient information in **any form** whether oral or recorded, on paper, or sent electronically.
5. True – PHI is **used** when shared, examined, applied, or analyzed by a covered entity that receives or maintains it.
6. True - PHI is **disclosed** when released, transferred, allowed to be accessed, or divulged outside the facility.
7. True
8. True
9. True
10. True
11. True
12. True
13. False – You can use/disclose PHI **without patient agreement for public health activities related to disease control and prevention.**
14. True
15. True
16. True
17. False – The Privacy Rule gives patients the right to request a history of **non-routine** disclosures of their PHI.
18. True
19. True
20. True
21. True