Florida Dept. of Corrections

Volunteer Application Process

Send the Application to Your Designated Primary Facility: Once completed, send the application to the facility you have chosen as your primary facility of service. For an institution, send it to the Assistant Warden of Programs (AWP); for Community Corrections, send it to the Circuit Administrator. You can find email/mailing addresses by looking at the **prison facility** or the **probation office** webpage(s).

For **Prison facilities**, put "Attention Assistant Warden of Programs" or "Attention AWP" in the email subject line.

For **Community Corrections** facilities, put "Attention Circuit Administrator" in the email subject line.

****Do not submit Volunteer applications to Chaplaincy staff.**

Submitting a Volunteer Application

You may download a copy of the electronic volunteer application below in two formats. This form is to be completed and submitted to the local facility of your choice. For an institution, send it to the Assistant Warden of Programs (AWP); for Community Corrections, send it to the Circuit Administrator. You will be contacted once your application has been processed. Approval, training, and scheduling are managed locally, so do not send applications directly to Volunteer Services.

Information on locating or contacting facilities throughout the state can be found at the Department of Corrections web site through the Facilities menu for **prison facilities** and for **probation offices**. Send your Volunteer application using the following:

For **Prison facilities**, put "Attention Assistant Warden of Programs" or "Attention AWP" in the email subject line.

For **Community Corrections** facilities, put "Attention Circuit Administrator" in the email subject line.

****Do not submit Volunteer applications to Chaplaincy staff.**

FLORIDA DEPARTMENT OF CORRECTIONS
VOLUNTEER APPLICATION

Personal Information

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

Address: _____ (City) _____ (State) _____ (ZIP Code)

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

Volunteer Group Name: _____

Security Clearance Information

Social Security #: _____ Date of Birth: _____

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

Drivers License #: _____ DL State: _____

Hair Color: Eye Color: Height: Weight:

1. Have you ever been arrested on a misdemeanor or felony charge? ☐ Yes ☐ No
   If yes, explain. (Use additional paper if necessary) _____
2. Have you ever been convicted on a misdemeanor or felony charge? ☐ Yes ☐ No
   If yes, explain. (Use additional paper if necessary) _____
3. Do you have a relationship (for example parent, spouse, friend, etc) or are you currently on the visitation list of anyone incarcerated? ☐ Yes ☐ No
   If yes, give the inmate's name, DC#, and your relationship to the inmate.
   Name: _____ DC#: _____ Relationship: _____
4. Have you ever worked for the Florida Department of Corrections? ☐ Yes ☐ No
   If yes, please indicate where and when you were employed. _____
5. Do you have any relatives working for the Department of Corrections? ☐ Yes ☐ No
   If yes, provide: Name: _____
   Relationship: _____ Work Location: _____

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

DC5-601A (Revised 5/19/14)

In accordance with s. 119.071(5)(a)2, your social security number is being collected in order to complete an FCIC/NCIC security report so that you can be approved as a volunteer. The Department will not use the social security number collected for any purpose other than the purpose provided above. Qualified applicants are considered without discrimination based upon race, color, national origin, age religious preference, or handicap. Intentionally falsifying or omitting information may result in disapproval of your volunteer application.

IN CONSIDERATION OF THE OPPORTUNITY TO SERVE IN THE DEPARTMENT OF CORRECTIONS AS A CITIZEN VOLUNTEER:

- I acknowledge that today I have been furnished with a copy of the volunteer rules,
- I have read, understood and signed an Acknowledgement of Responsibility to Maintain Confidentiality of Medical Information, DC2-813 and the PREA training "Read and Sign" for volunteers.
- I understand that I am responsible for reading and complying with the rules.
- I will work in cooperation with staff.
- I will honor the civil and legal rights of all offenders/inmates.
- I will not use my official position to secure privileges or advantages for myself.
- I will report unethical behavior or rule violations to an appropriate Department supervisor.
- I will not discriminate against any offender/inmate, employee, or prospective employee on the basis of race, gender, creed, national origin, or religious preference.
- I acknowledge the drug-free workplace policy of the Department of Corrections and I know I am subject to random drug testing.
- I agree to abide by the policies and procedures regarding confidentiality of records and medical information.

WAIVER OF LIABILITY

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

I confirm that all the information on the application is correct and have read the Acknowledgement of Responsibilities, Waiver of Liability, and agree to abide by the conditions therein.

Signature: _____ **Date:** _____

For Those Completing Regular Volunteer Training: _____

Person Conducting Volunteer Training: _____

Location: _____

Official Use:

F.A.S.T. Pin #:				
Training Date:		**FCIC/NCIC[1] Date:**		**Hits:** ☐ Yes ☐ No
Approved:			**Date:**	

(Approving Authority[2])

Signature of Volunteer _____ Date: Volunteer's Printed Name: _____

[1] An annual background check should be done for each active regular service volunteer. The temporary volunteer badge is produced in accordance with "Identification Cards," Procedure 602.056.

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

DC5-601A (Revised 5/19/14)

In accordance with s. 119.071(5)(a)2, your social security number is being collected in order to complete an FCIC/NCIC security report so that you can be approved as a volunteer. The Department will not use the social security number collected for any purpose other than the purpose provided above. Qualified applicants are considered without discrimination based upon race, color, national origin, age religious preference, or handicap. Intentionally falsifying or omitting information may result in disapproval of your volunteer application.

FLORIDA DEPARTMENT OF CORRECTIONS

ACKNOWLEDGMENT OF RESPONSIBILITY TO MAINTAIN CONFIDENTIALITY OF MEDICAL INFORMATION

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

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

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

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

Signature of Employee/Volunteer	Employee's/Volunteer's Printed Name
Date	Last 4 Digits of Social Security Number