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 Confidentiality (4 pgs)
State of FL Oath of Loyalty
State of Florida Retirement Form
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
755 Lovejoy Road NW
Fort Walton Beach, FL 32548-3844 Office 850-863-3628
FAX 850-315-0289
www.floridaonedmat.com

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.

EMPLOYMENT PROCESS

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

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: ____/____/____ (MONTH / DAY / YEAR) TO: ____/____/____ (MONTH / DAY / YEAR) HOURS PER WEEK: ______ (______________________) 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: ____/____/____ (MONTH / DAY / YEAR) TO: ____/____/____ (MONTH / DAY / YEAR) HOURS PER WEEK: ______ (______________________) 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: ____/____/____ (MONTH / DAY / YEAR) TO: ____/____/____ (MONTH / DAY / YEAR) HOURS PER WEEK: ______ (______________________) 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: ______________

Employer, remove this section upon completion of the selection process.

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:
- 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** ______

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 . . . **F** ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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.) ▶ **H** ______

For accuracy, complete all worksheets that apply.
- 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

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

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** ☐ Single ☐ Married ☐ 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.** ▶ ☐	

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)

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: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately }	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 *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* 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

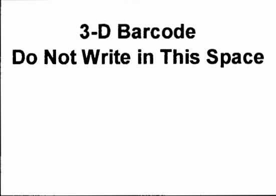
2. Form I-94 Admission Number: ____________

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*)



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)*:				**3-D Barcode Do Not Write in This Space**
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 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		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. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 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. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

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**, located on the department's Intranet web site, 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-36, 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,** is located on the department's Intranet website. I also understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office.

- The department's **Equal Employment Opportunity Policy**, **Americans with Disabilities Act Accommodations Policy**, **Sexual Harassment Policy**, and **Equal Opportunity in Service Delivery Policy** are located on the department's Intranet website. These policies address the equal opportunity requirements of federal and state law with regard to employment and the provision of services to clients. I also understand that I may obtain clarification or additional information from my supervisor, servicing human resource office, or the Equal Opportunity Section staff in the Bureau of Human Resource Management.

- The **Drug-Free Workplace Policy** is located on the department's Intranet website. This policy 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 by contacting the servicing human resource office. Additional information regarding the drug free workplace may be found in Section 112.0455, Florida Statutes. I also understand my compliance with this policy is a condition of employment.

- The department's **Violence in the Workplace Policy** is located on the department's Intranet website. I also understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office.

- 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 reviewed the current payroll schedule, located on the department's intranet website. I understand that it is my responsibility to accurately submit my electronic attendance and leave record in People First to my supervisor/manager no later than the Friday following the close of the pay period and that intentional falsification of this leave record shall be cause for disciplinary action, up to and including dismissal. I also understand that failure to submit my leave and attendance record may result in not receiving a payroll warrant timely. I am aware that

it is my responsibility to monitor my accumulated leave balances each pay period and notify the servicing human resource office of any discrepancy immediately.

- The State of Florida's **Employee Information Center**. I understand that it is my responsibility to access and monitor my biweekly earning statement, and to certify that my earnings are accurate in accordance with my submitted timesheet and my appointed salary. Any discrepancies must be reported to my servicing human resource office as soon as they are discovered. I also understand that I can choose to enroll in electronic W-2 forms through the Employee Information Center.

- The department's **Background Screening Policy** is located on the department's Intranet website. Additional information regarding background screening may be found in Section 110.1127 and Chapter 435, Florida Statutes. I also understand that I may obtain clarification or additional information from my supervisor or the servicing human resource office. I also understand my compliance with this policy is a condition of employment.

- The **Health Insurance Marketplace Coverage Options and Your Health Coverage** document is located on the department's Intranet website. I have been provided a hard copy of this document.

- Membership in the **Florida Retirement System (FRS)** is compulsory for all employees working in a regularly established position, including Career Service, Selected Exempt Service (SES) or Senior Management Service (SMS) employees. I understand that as a member of the FRS, I am required to contribute 3% of gross compensation (pre-tax) to the FRS; this employee contribution is not optional and will be automatically deducted from any retirement-eligible compensation. Reemployed FRS retirees who were initially rehired in an FRS-eligible position on or after July 1, 2010, and Deferred Retirement Option Program (DROP) participants are not required to pay contributions to the FRS.

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

Secondary or Dual Employment

☐ I am not presently receiving compensation from another job (state or non-state).

☐ I am currently receiving compensation from another state agency.
If you are currently receiving compensation from another state agency, you must complete a "Dual Employment and Compensation Request". You are not permitted to work in a secondary capacity until you receive approval from your servicing human resource office.

☐ I am currently receiving compensation from a job outside of state government (including a state university).
If you are currently receiving compensation from an entity outside of state government, you must complete an "Outside Employment Request". You are not permitted to work in a secondary capacity until you receive approval from your servicing human resource office or, if necessary, the Ethics Officer in the General Counsel's office.

Check appropriate box(es) and initial here: _____

Personnel Record Confidentiality

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

Category	Indicator Name	Description
1	Sworn / Certified	Pursuant to Chapter 119, F.S., individuals who are current or former holders of a sworn / certified position in law enforcement are permanently eligible for this exemption, even if they are no longer active.
2	Restricted	Pursuant to Chapter 119, F.S., individuals who are current or former holders of specified positions (non-sworn / certified), but did involve any of the various judicial, enforcement or prosecutorial duties described in subparagraphs 119.071(4)(d) 1-6, F.S.; or the duties of various personnel of the Department of Juvenile Justice, as described in subparagraph 119.071(4)(d)7, F.S.) are permanently eligible for this exemption, even if they are no longer active.
3	Restricted Relative	Pursuant to Chapter 119.071(4)(d), F.S., individuals who are the spouse or children of current or former holders of a sworn / certified position in law enforcement are eligible for this exemption. Eligibility for this indicator may change in case of a divorce.
4	Protected Identity	Pursuant to court-issued restraining orders or other legal documents, identified employees may document their legal right to have their home and work address information exempted from public record requests. Eligibility for this indicator may change in cases where the court order expires.

☐ If any of the preceding criteria apply to you and you are invoking your rights under 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: _____

FOR OTHER PERSONAL SERVICES (OPS) EMPLOYEES ONLY

OPS General Information Sheet

Degree-Seeking Students
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 and initial here: _____

State of Florida 401(a) FICA Alternative Plan (Mandatory)
OPS employees are not covered by Social Security and are not subject to Social Security taxes (Medicare only). Instead, eligible OPS employees will be enrolled in a qualified retirement plan, administered by BENCOR. Enrollment in this plan is mandatory and automatic, unless you are also employed in a position that is covered by the Florida Retirement System (FRS) or you are retired from the FRS.

☐ Yes, I am retired from the Florida Retirement System (FRS). *Notify your servicing human resource office immediately to avoid improper deductions from your pay.*

☐ Yes, I currently work for DOH or another employer in a position that is covered by the FRS. *Notify your servicing human resource office immediately to avoid improper deductions from your pay.*

☐ No, I am neither a FRS retiree or employed with any employer in a covered FRS position. I understand that I will be enrolled in the FICA-Alternative Plan.

Check appropriate box(es) and initial here: _____

This is to certify that I have read and understand the information contained or referenced in this 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.

____________________	________________________________	__________
Print Name	Employee Signature	Date
____________________	________________________________	__________
Print Name	Supervisor Signature	Date

Acceptable Use and Confidentiality Agreement

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

Security and Confidentiality Supportive Data

W S

☐ ☐ I have been advised of the location of and have access to the Florida Statutes and Administrative Rules.

☐ ☐ I have been advised of the location of and have access to the core Department of Health Policies, Protocols and Procedures and local operating procedures.

____

____

____

Position-Related Security and Confidentiality Responsibilities

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

☐ ☐ I have been given copies or been advised of the location of the following specific Florida Statutes and Administrative Rules that pertain to my position responsibilities:

____

____

____

☐ ☐ I have been given copies or been advised of the location of the following specific core DOH Policies, Protocols and Procedures that pertain to my position responsibilities:

____

____

____

☐ ☐ 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 DOH Employee Handbook and understand the disciplinary actions associated with a breach of confidentiality.

☐ ☐ I understand that a security violation may result in criminal prosecution and disciplinary action ranging from reprimand to dismissal.

☐ ☐ I understand my professional responsibility and the procedures to report suspected or known security breaches.

The purpose of this Acceptable Use and Confidentiality Agreement is to emphasize that access to all confidential information regarding a member of the workforce or held in client health records is limited and governed by federal and state laws. Confidential information includes: the client's name, social security number, address, medical, social and financial data and services received. Data collection by interview, observation, or review of documents must be in a setting that protects the client's privacy. Information discussed by health team members must be held in strict confidence, must be limited to information related to the provision of care to the client, and must not be discussed outside the department.

DOH Worker's Signature	**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 the Florida Computer Crimes Act, if applicable.

The Department of Health has authorized you to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department's disciplinary standards and in addition to departmental discipline, the commission of computer crimes may result in felony criminal charges. The *Florida Computer Crimes Act, Chapter 815, F.S.*, addresses the unauthorized modification, destruction, disclosure or taking of information resources.

I have read the above statements and by my signature acknowledge that I have read and been given a copy of, or been advised of the location of, the *Florida Computer Crimes Act, Chapter 815, F.S.* I understand that a security violation may result in criminal prosecution according to the provisions of *Chapter 815, F.S.*, and may also result in disciplinary action against me according to Department of Health policy.

The minimum information resource management requirements are:

- Personal passwords are not to be disclosed. There may be supplemental operating procedures that permit shared access to electronic mail for the purpose of ensuring day-to-day operations of the department.
- Information, both paper-based and electronic-based, is not to be obtained for my own or another person's personal use.
- Department of Health data, information, and technology resources shall be used for official state business, except as allowed by the department's policy, protocols, and procedures.
- Only approved software shall be installed on Department of Health computers (DOHP 50-10c-10).
- Access to and use of the Internet and email from a Department of Health computer shall be limited to official state business, except as allowed by the department's policy, protocols, and procedures.
- Copyright law prohibits the unauthorized use or duplication of software.

DOH Worker's Signature	**Date**	**Supervisor or Designee Signature**
Print Name	**Date**	**Print Name**

W=Worker S=Supervisor

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)

Florida Retirement System (FRS) - Certification Form

This form is **not** an offer of employment or an enrollment form. If hired, a Retirement Choice kit may be mailed to your home with an enrollment form.

Name ____________________ SSN ____________________

Agency Name ____________________

Previous or Current FRS Employer ____________________

PLEASE COMPLETE SECTION I, II, III, OR IV

I. I have **never** been a member of a State of Florida administered retirement plan.

STOP HERE

SIGNATURE ____________________ DATE ____________________

II. I was or currently am a member of the following State of Florida administered retirement plan (also complete Section III **or** IV)[1]

- ☐ FRS Pension Plan (incl. DROP)
- ☐ FRS Investment Plan
- ☐ State University System Optional Retirement Program (SUSORP)
- ☐ State Community College Optional Retirement Program (SCCORP)
- ☐ Senior Management Service Optional Annuity Program (SMSOAP)
- ☐ Other

III. I am **not retired** from any State of Florida administered retirement plan. I understand that if it is later determined that I was a retiree and was reemployed during the first 6 calendar months after I retired or after my DROP termination date, or at any time during the 7th through 12 months after I retired or after my DROP termination date, I **must repay** all unauthorized benefits received (see Section IV for details), or, if in the Investment Plan, terminate my employment. **My employer may also be liable for repaying any unauthorized benefits I received.**

SIGNATURE ____________________ DATE ____________________

IV. I am **retired** from a State of Florida administered retirement plan. My FRS Pension Plan retirement effective date, DROP termination date, or date I received my first distribution from the FRS Investment Plan, SUSORP, SCCORP, SMSOAP, or other plan was ______________________.

If I am initially reemployed by an FRS-covered employer on or after July 1, 2010, I will not be permitted to participate in a State of Florida administered retirement plan to earn an additional retirement benefit.

I understand that as a Pension Plan retiree:

a. If I am employed by an FRS-covered employer in **any type of position**[2] during the **first 6 calendar months** after I retired or after my DROP termination date, my retirement and DROP status are voided, all retirement and DROP benefits I received **must be repaid**,[3] and I must reapply for retirement in order to receive future benefits.

b. If I am reemployed by an FRS-covered employer at any time during the 7th through the 12th months after I retired or after my DROP termination date, my monthly retirement benefit must be suspended[4] and any unauthorized benefits received must be repaid.[3] **My employer may also be liable for repaying any unauthorized benefits I received.**

I understand that as an Investment Plan, SUSORP, SCCORP, or SMSOAP retiree:

a. If I am employed by an FRS-covered employer in **any type of position**[2] during the **first 6 calendar months** after I retired, I **must repay**[3] any benefits received or terminate employment for an additional period to satisfy the 6 calendar month termination requirement.

b. If I am reemployed by an FRS-covered employer at any time during the 7th through the 12th months after my retirement, I will not be eligible for additional distributions until I terminate employment or complete 12 calendar months of retirement.[4]

SIGNATURE ____________________ DATE ____________________

Retiree Definition

You are considered retired if:

1. You have received any benefits under the FRS Pension Plan (including DROP), or
2. You have taken any distribution (including a rollover) from the FRS Investment Plan, or alternative retirement programs offered by state universities (SUSORP), state community colleges (SCCORP), state government for senior managers (SMSOAP), or local governments for senior managers.

---

[1] If you are not retired and earned FRS service after certain periods in 2002 (depending on your employer), you must rejoin the FRS retirement plan you were enrolled in when you terminated FRS-covered employment. You may have a one-time 2nd Election to switch FRS retirement plans. Also, alternative retirement programs are available to certain employees. Contact your employer for deadline and other information.

[2] Positions include OPS, temporary, seasonal, substitute teachers, part-time, full-time, regularly established, etc.

[3] Florida law requires a return of all unauthorized Pension Plan benefit payments or Investment Plan distributions received by a member who has violated the FRS termination or reemployment provisions. Similar provisions apply to unauthorized SUSORP, SCCORP, or other state-administered plan distributions – contact that plan's administrator for details.

[4] There are no reemployment exemptions/exceptions for Pension Plan members whose effective date of retirement or DROP termination date is on or after July 1, 2010 or Investment Plan, SUSORP, SCCORP, or SMSOAP members who retire on or after July 1, 2010.

EMPLOYERS: RETAIN THIS FORM IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT SEND THIS FORM TO THE FRS, UNLESS REQUESTED.

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
755 Lovejoy Rd NW
Ft. Walton Beach, Florida, 32548-3844
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

____JOB
TITLE DATES OF VOLUNTEER/EMPLOYMENT

Specify the days and time frames you are available to volunteer: ___________________

Day of Week	Hours	Day of Week	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?
Yes ______ No ______ If answer is yes, please explain (including types of offenses and dates):

____

It shall be a misdemeanor of the first degree to fail to disclose, by false statement, misrepresentation, impersonations or 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 Statues. 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 responsabilities of position. Explained requirements OPSEC, Operational Security, use of Social Media.

Screening Required: Yes __X____ **No** ______ **Date Screening Completed:** _________

Date Orientation Completed: _______________

WORK ASSIGNMENT
(For Agency Use Only)

State Medical Response Team
Program

Ft. Walton Beach, Florida
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/FACILTY

755 Lovejoy Rd NW Ft. Walton Beach, Florida, 32548-3844
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/FACILTY

755 Lovejoy Rd NW Ft. Walton Beach, Florida, 32548-3844
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

____
Date of Birth

Ethnicity (Check ONLY One)

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino

Sex: ☐ Male ☐ Female

____
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 (FL MRC Coordinator) Date: ________________
Office ACRONYM: ___________________________ TELEPHONE: _________________________________

EMPOYEE 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 And/or Flair Access: Yes No

Contact with Vulnerable Persons: Yes No

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

RegionOne SMRT
755 Lovejoy Rd NW
Ft. Walton Beach, Florida, 32548-3844
Office 850-863-3628
FAX 850-315-0289
www.floridaonedmat.com

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: ______________________

DH 1475, 10/05 Retain this form to record your volunteer hours

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/disclo-sure 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 confidentially, 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