VICTIM/WITNESS ASSISTANCE PROGRAM

AGREEMENT OF CONFIDENTIALITY

As a Victim Assistance Volunteer Applicant, I understand that confidentiality is imperative to the Program's effectiveness. Additionally, confidentiality is necessary to establish and maintain trust with the victims and agencies with whom I will be working.

I understand that all information obtained through observation, reading of agency files, and direct or indirect contact with victims, remains confidential to the Prosecuting Attorney's Office and the Victim/Witness Assistance Program.

I fully agree to abide by these policies of confidentiality. I also understand that any breach of this agreement will result in immediate loss of privileges associated with the Prosecuting Attorney's Office and the Victim/Witness Assistance Program. Violation of this agreement will also result in immediate dismissal of volunteer status with the Victim/Witness Assistance Program.

I have read this form and agree to the conditions therein.

____

APPLICANT'S PRINTED NAME **DATE OF BIRTH**

____

APPLICANT'S SIGNATURE **TODAY'S DATE**

____

APPLICANT'S SOCIAL SECURITY NUMBER

Taken, subscribed, and sworn to before me this ____________day of ______________, 20_____.

My commission expires:________________________________

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NOTARY PUBLIC