



Volunteer Application

Please print clearly

Personal Contact Information

Dr. Mrs. Mr. Ms.
(Circle one above)

Last Name _____ First Name _____ MI ____
Home Address: Street _____ Apt. # _____
City _____ State _____ Zip Code _____
Home # (____) _____ Cell Phone # (____) _____ Work Phone # (____) _____
E-mail Address _____ Personal Pager # (____) _____
Date of Birth _____ Social Security Number: _____ (This is strictly used for
your background check and for the ICS trainings that are required)
Driver's License/State ID Number: _____ Expiration Date: _____

Although the focus of our unit is on local emergencies, would you like us to call you in case of a statewide or national emergency (such as Hurricane Katrina relief efforts in 2005)? Please circle any that apply:

National **Statewide** **Huron County** **My town only**

Are you interested in animal response? **Yes** **No**

If volunteers are needed for response to an emergency during the hours when you'd be working, is it ok to contact you at your place of employment? **Yes** **No**

Emergency Contact – To be notified in case of an emergency.

Contact _____ Phone Number (____) _____ Relationship _____
Address _____ City _____ State _____ Zip _____

Background Check

The Huron County Medical Reserve Corps may require a background check for certain volunteer roles. This is done for safety and security concerns of all citizens of the county and is not meant to be an intrusion. **You may opt out of this without affecting your status as an MRC volunteer.** Feel free to call Jenny Ridge at the Huron County General Health District if you have any questions.

____ Yes, I _____, hereby authorize the Huron County Sheriff's Department to conduct a criminal background check on me and supply any resulting information to the Huron County General Health District so that I may volunteer for the Ohio Medical Reserve Corps.

____ No, I am opting out of having my background checked and it will not affect my MRC status.

Employment

Employment information:

Occupation _____ (check) Full Time Part Time Retired Student
Employer _____ Address _____
General Phone Number (____) _____ Your extension _____ Fax # (____) _____

Education

Education (check highest level) High School College Graduate School Other _____

School Name: _____ Location: _____

Type of Degree: _____ Major/Specialization: _____ Year Graduated: _____

License (Professionals with a current license or certification in any health or mental health field)

Circle all applicable:	License/Certification #	Expiration Date
1. M.D./ D.O. _____		
2. D.V.M./ V.M.D. _____		
3. D.D.S./D.M.D. _____		
4. D.C. _____		
5. R.N. _____		
6. L.P.N. _____		
7. EMT/ Paramedic _____		
8. P.A/ N.P. _____		
9. Pharmacist _____		
10. Psychiatrist/Psychologist _____		
11. Other Mental Health Practitioner _____		
12. Social Work LSCSW LMSW LBSW _____		
13. Other health related degrees or licenses _____		
14. Do you have prescriptive authority?	Yes	No

***** Please attach a copy of your current professional license to this application. *****

Certifications & Training (Check any that apply)

Certifications	Most Recent Date	Certifying Agency
<input type="checkbox"/> CPR	_____	_____
<input type="checkbox"/> First Aid	_____	_____
<input type="checkbox"/> Disaster Training	_____	_____
<input type="checkbox"/> CERT	_____	_____
<input type="checkbox"/> Bloodborne Pathogens & Standard Precautions	_____	_____
<input type="checkbox"/> Military Medical Training	_____	_____

Training (Check/circle any that you have attended)

Other Training (list below)

Incident Command System 100/200 other

NIMS-700

Epidemiology

Bioterrorism

Terrorism & emergency response to terrorism

Skills

What languages do you **speak** or understand other than English? Please list and indicate level of fluency: (Include sign language)

Languages spoken:

level of fluency (*circle one*)

Read and write?

Excellent Fair Poor

Yes No

Excellent Fair Poor

Yes No

Please list any other work related skills you bring to the Medical Reserve Corps.

Please list additional specialized skills you bring to the Medical Reserve Corps.

Areas of Interest Indicate your areas of interest by checking below (you may check more than one area)

During an Emergency (At a mass vaccination or pharmaceutical distribution site or shelter)

Licensed volunteers

- Assist with vaccinations
- Pharmaceutical distribution

- Mental health consultation
- Medical screening
- Staff shelters

Non-Licensed volunteers

- Greet patients
- Educate patients (on the vaccination procedure)
- Language interpreter/translator
- Public information contact
- Computer support

- Assist with clinic/shelter flow
- Forms completion and collection
- Data entry
- Supply/stock manager
- Clinic/shelter manager
- Other logistics support
- Other as needed

Non-Emergency Opportunities (Check your preferences)

Work Directly with Patients/Clients

- Assist with Flu Clinics
- Provide patient education
- Language interpreter/translator
- Assist in Dental Clinic
- Assist patients with forms
- Assist with children's health screenings

Provide Indirect Support (little or no patient/client contact)

- Provide health program assistance
- Computer support
- Clerical assistance
- Medical Records assistance
- Provide education and/or presentations on health topics
(check topics of interest or list your expertise)
- Diabetes Prescriptions/pharmacy
- Obesity/healthy lifestyles
- Smoking cessation
- Other topics _____

Availability Indicate times when you are available to volunteer (for non-emergency)

	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday
<i>Circle all that apply</i>	Morning	Morning	Morning	Morning	Morning	Morning	Morning
	Noon	Noon	Noon	Noon	Noon	Noon	Noon
	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
	Evening	Evening	Evening	Evening	Evening	Evening	Evening

Are you part of an emergency/disaster plan with any other organization? (Such as the American Red Cross, a local hospital, etc.)

If yes, please list below. **Yes** **No**

Who would you respond to first if on multiple lists? _____

How did you learn about the Medical Reserve Corps? _____

Do you have any personal health issues that would impact your ability to volunteer? Yes No
(For example allergies, medication issues, disabilities, special needs, or being treated for a medical condition) If yes, please either list here or speak personally with the MRC Coordinator.

Photo Permission

Yes, __, I give my permission to be interviewed and/or photographed for publicity purposes. I understand that this information may appear publicly in a newspaper or other advertising media. **No expiration on this permission unless notified.**

Signature of applicant Date

Credentials Verified

I give my permission to have my credentials verified.

Signature of applicant Date

State of Ohio Data Base

I understand that by voluntarily providing my information to the Ohio Citizen Corps and the Ohio Medical Reserve Corps, I am indicating a willingness to volunteer during a governmentally declared emergency that requires assistance from the medical community.

Registering with the Ohio Citizen Corps and the Ohio Medical Reserve Corps is not a substitute for the appropriate professional license to practice in Ohio. I understand that it is my responsibility to properly maintain my professional license in good standing and that an Ohio license in good standing and participating in any required training or education is a prerequisite to volunteering.

I further understand that by saying "Yes" I hereby certify and affirm all the information I have provided is true and accurate to the best of my knowledge.

I also acknowledge that the Ohio Citizen Corps and the Ohio Medical Reserve Corps may verify the information I have provided as a part of the volunteering process.

The Ohio Citizen Corps Database is maintained by the Ohio Community Service Council. We are entering your information in this database for you. You are encouraged to use your account we are setting up for you at www.servohio.org. The site is set up to allow you to keep your own information current and customize your volunteer experience. Response is ALWAYS completely voluntary.

Self Attest (circle one): Yes No

Signature of Applicant

Date

References

Please include 2 work references and 1 personal reference.

Name

Telephone Number

1. _____

2. _____

3. _____
