Volunteer Registration

Today's Date:

Personal Contact Information

Last Name________________________________First Name________________________Middle__________________

Home Address____Apt. No.________________

City______________________State_______Zip Code_________County of Residence________________________

Home Phone (__)______________Work Phone (__)______________ext.____Mobile Phone (__)______________

Pager Number (__)_____________Fax Number (__)________________Email Address________________________
Type of Pager(leave #, voice, text message)

Work Contact Information

Occupation _____________________________________ Specialty ____
☐ Full time ☐ Part time ☐ Retired ☐ Student

Employer __________________________________Address_______________________________________

City_____________________________State _____________ Zip Code _______________

Birth Date ________________ Place of Birth _______________ Age __________ Gender☐ Male ☐ Female

Social Security Number____

Marital Status _____________________ Spouse's Name _____________________

Driver's License Number _______________________ State Issued _______ DL Expiration Date ______________

Are you an employee of a local health department? ☐ Yes ☐ No If so, which one? ____________________

Have you ever been convicted of a felony? ☐ Yes ☐ No
Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No

What is the highest level of education you have completed? ____

Emergency Contact Information

Name ____ Relationship________________________

Address ___________________________________City___________________State_____Zip Code______________

Daytime Phone Number (__)___________________Evening Phone Number (__)_________________________________

Preferred Tasks

Please number in order of preference your preferred tasks in the event of an emergency:

- ☐ Assist clients with forms
- ☐ Assist with client education
- ☐ Assist with flu clinics
- ☐ Assist with health screenings
- ☐ Computer Support
- ☐ Data entry
- ☐ Decontamination
- ☐ Education and Training
- ☐ Environmental Health
- ☐ Evidence preservation
- ☐ Evacuation
- ☐ Greeter
- ☐ Ham Radio Operator
- ☐ Immunizations
- ☐ Infectious Disease/Contact Tracing
- ☐ Interpreter Services
- ☐ Injured or deceased animals
- ☐ Laboratory Capacity
- ☐ Mental Health
- ☐ MRDD Services
- ☐ Registration
- ☐ Security/Law Enforcement
- ☐ Supply Stock
- ☐ Strategic National Stockpile
- ☐ Surveillance
- ☐ Trauma
- ☐ Triage

Other, please describe

Do you speak or read a language other than English? ☐ Yes ☐ No **If so, which one?** ________________

Do you have any public health response experience? ☐ Yes ☐ No **If so, describe** ___________________

Do you have any disaster or crisis training or experience? ☐ Yes ☐ No **If so, describe** ________________

Immunization History

- ☐ **Tetanus/Diphtheria** **Date:**_____________
- ☐ **Hepatitis A** **Date:**_____________
- ☐ **Hepatitis B** **Date:**_____________
- ☐ **Flu** **Date:**_____________
- ☐ **Smallpox** **Date:**_____________

Previous Training

Please check all training or volunteer opportunities that apply:
Please provide copies of certificates (if possible) that apply:

	Training	Certificate		Training	Certificate
☐	**Advanced Disaster Life Support (ADLS)**	_____	☐	**Hazmat Awareness Level Training**	______
☐	**Advanced Trauma Life Support (ATLS)**	______	☐	**Incident Command Structure (ICS)**	______
☐	**Basic Cardiac Life Support (BCLS)**	______	☐	**Pediatric Life Support (PALS)**	______
☐	**Basic First Aid**	______	☐	**Unified Command Structure (UCS)**	______
☐	**CERT Training**	______	☐	**WMD Awareness Level Training**	______
☐	**Cardiopulmonary Resuscitation (CPR)**	______	☐	**American Red Cross**	______
☐	**Critical Incident Stress Debriefing (CISD)**	_____	☐	**Disaster Medical Assistance Team**	______
☐	**Hazmat Awareness Level Training**	_____	☐	**Disaster Mortuary Operational Response Team**	______

Other Certifications or training: ____

Availability

Are you part of an emergency/disaster plan with another organization? ☐ **Yes** ☐ **No**

How did you learn about the Medical Reserve Corps? ______________________________

Please indicate when you are available for training.

☐ **Sunday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Monday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Tuesday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Wednesday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Thursday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Friday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**
☐ **Saturday**	☐ **Morning**	☐ **Afternoon**	☐ **Evening**

The Medical Reserve Corps recognizes its responsibility to volunteer staff to assure fair and equal treatment and will not discriminate on the basis of color, religion, sex, age or national origin or against any qualified handicapped individual, or disabled veteran. I understand that I am applying for an unpaid volunteer position and that this is not an application for or contract of employment. I further agree that as a Medical Reserve Corps Volunteer I may not accept payment for my services and that I will incur the cost of transportation. I will also take required training when applicable. The statements made on the registration are true, complete and accurate to the best of my knowledge. I understand that any misrepresentation, omission of information, or misleading and incomplete data shall result in disqualification from consideration or dismissal as a volunteer. The Medical Reserve Corps reserves the right to disqualify or reject any volunteer.

X____ ____________________
Signature Date

Please return this form to:

Monica Alles-White
Glendale Health Committee
Glendale Village Office
30 Village Square
Glendale, OH 45246