

FULTON COUNTY OHIO MEDICAL RESERVE CORPS
VOLUNTEER REGISTRATION

Please print clearly

Today's date _____

Personal Contact Information

Title: Dr. Mrs. Mr. Ms. _____

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 _____

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

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 check off your preferred tasks during an emergency:

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

Other, please describe _____

Do you speak or read a language other than English? Yes No If so which one? _____

Do you have any disaster/emergency response experience? Yes No If so, describe _____

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 _____

Previous Training

Please check all training or volunteer opportunities that apply:

- | | |
|---|--|
| <input type="checkbox"/> Advanced Disaster Life Support (ADLS) | <input type="checkbox"/> American Red Cross |
| <input type="checkbox"/> Advanced Trauma Life Support (ATLS) | <input type="checkbox"/> Disaster Medical Assistance Team |
| <input type="checkbox"/> Basic Cardiac Life Support (BCLS) | <input type="checkbox"/> Disaster Mortuary Operational Response Team |
| <input type="checkbox"/> Basic Disaster Life Support (BDLS) | |
| <input type="checkbox"/> Basic First Aid | |
| <input type="checkbox"/> CERT training | |
| <input type="checkbox"/> Cardiopulmonary Resuscitation (CPR) | |
| <input type="checkbox"/> Critical Incident Stress Debriefing (CISD) | |
| <input type="checkbox"/> Hazmat Awareness Level training | |
| <input type="checkbox"/> Incident Command Structure (ICS) | |
| <input type="checkbox"/> Pediatric Life Support (PALS) | |
| <input type="checkbox"/> Unified Command Structure (UCS) | |
| <input type="checkbox"/> WMD Awareness Level training | |

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:

- | | | | |
|------------------------------------|----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Sunday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Monday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Thursday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Friday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Saturday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> 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

PHOTO PERMISSION:

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.

Signature

Date

CREDENTIALS VERIFIED:

I give my permission to have my credentials verified.

Signature

Date

STATE OF OHIO DATA BASE:

I give my permission to have my name added to the State of Ohio Data Base for liability purposes.

Signature

Date

Please return this form to:

Brooke Schuette MPH
Fulton County Ohio MRC Coordinator
brookeschuette@fultoncountyoh.com
606 S. Shoop Avenue
Wauseon, OH 43567
(419) 337-0915
or FAX
(419) 337- 0561

