



MACOUPIN COUNTY MEDICAL RESERVE CORPS VOLUNTEER APPLICATION

Name: _____

Address: _____

Telephone # _____ Cell # _____

Work # _____ Email: _____

Employer: _____

- Full Time
- Part Time
- Retired
- Other: _____

Professional Information (mark or circle all that apply)

- Physician: Area of Specialty: _____ Board Certified? Yes No
- Nurse: RN LPN Nurse Practitioner Do you have prescriptive authority? Yes No Area of Specialty: _____
- Emergency Medical Technician
- Paramedic
- Pharmacist
- Mental Health Practitioner Psychologist Other: _____
- Social Worker
- Physician Assistant
- Nurse Assistant
- Medical Assistant
- Dentist
- Veterinarian
- Environmental Health Specialist
- Health Educator
- Health Technician Type _____
- Public Relations
- Media/ Communications
- Clergy Denomination: _____

- Faith-based Recruit (Please mark here is you received this application via your church)
- Other _____

License & Certifications

License Number & Discipline: _____

Have you ever had your professional license suspended or revoked? Yes No
If yes, please explain: _____

Specialty Information

Specialty/Subspecialty: _____

Board Certifications or other Certifications: _____

Specialty Skills related to emergency situations: _____

Other Skills

Are you CPR certified?	Yes	No
Are you AED certified?	Yes	No
Are you first aid certified?	Yes	No

Language fluency, besides English _____

Response Time and Estimated Time Available

- | Respond Time | Estimated Time Available |
|--|---|
| <input type="checkbox"/> Able to respond immediately | <input type="checkbox"/> 1 – 3 Days |
| <input type="checkbox"/> Able to respond in 24 hours | <input type="checkbox"/> 3 Days to 1 week |
| <input type="checkbox"/> Able to respond in 48 hours | <input type="checkbox"/> 1 – 2 weeks |

Are you willing to volunteer in a disaster, even if your medical expertise may not be needed?
(ie: flood, assist with sandbagging, helping people to safety, ect.) Yes No

Are you part of any other emergency/disaster alert system? Yes No

Please List

Do you have children or family members that would need care in the event that you are activated? Yes No Emergency Contact # _____

I do hereby give the Macoupin County Medical Reserve Corps permission to inquire into my driving record, volunteer history and police record. I further give permission to the holder of any such records to release the same to the Macoupin County Medical Reserve Corps. I hereby hold the Macoupin County MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of the information about me. I further hold harmless any individual, agency, business or corporation that provides document to the Macoupin County MRC. I understand that the Macoupin County MRC will use this information as part of its verification of my volunteer application. I further understand that as a Medical Reserve Corps volunteer, I am not paid for my services.

Volunteer Consent for Release Information

I do hereby give the Macoupin County MRC permission to release personal information with local, state and federal emergency management agencies and other Health and Human Services agencies as needed.

Signature

Date

Driver's License # for Background Check

Mail To:

Macoupin County Public Health Department
Attn: David Hopper
805 North Broad Street
Carlinville, IL 62626
Or Fax application to: 217-839-3809