WEST CENTRAL MEDICAL RESERVE CORPS REGISTRATION FORM

VOLUNTEER INFORMATION — PLEASE PRINT

Full Name: Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ | Suffix:

Current address:

City: | State: | ZIP Code:

County: | Home Phone: | Work Phone:

Cell Phone: | Pager: | Fax:

E-mail:

Current Work Status: Full Time ☐ Part Time ☐ Retired ☐ Student ☐

Occupation: | Specialty/Licensure:

Licensure # / Certification # : | Exp. Date: | State of Registration:

Current employer:

Employer address:

City: | State: | ZIP Code:

Date of Birth: | Age: | Gender: M ☐ F ☐ | Marital Status:

Spouse Name: Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ | Suffix:

Driver's License State Issued: | DL Number: | Expires:

Local Health Department Name:

Local Public Health Employee? Yes ☐ No☐ | Felony? Yes ☐ No ☐ | Misdemeanor? Yes ☐ No ☐

Can we share your information with the Ohio MRC? Yes ☐ No ☐

PREFERRED TASKS DURING AN EMERGENCY (CHECK THAT APPLIES)

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	☐
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):

SPEAK OR READ LANGUAGE OTHER THAN ENGLISH?

Vietnamese	☐	Chinese	☐	Spanish	☐	Other Language	☐

List other language(s):

☐ Check if you have any disaster/emergency response experience and describe below:

☐ Check if you have any public health response experience and describe below:

☐ Check if you have ever had any disaster or crisis training or experience

REGISTRATION INFORMATION CONTINUED ON BACK

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Can you travel? Within 50 mile radius of home ☐ Within the state of Ohio ☐ Outside of the state ☐

PREVIOUS TRAING (CHECK ALL TRAINING THAT APPLIES)			
Advanced Disaster Life Support (ADLS)	☐	Advanced Trauma Life Support (ATLS)	☐
Basic Cardiac Life Support (BCLS)	☐	Basic Disaster Life Support (BDLS)	☐
Basic First Aid	☐	CERT Training	☐
Cardiopulmonary Resuscitation Training (CPR)	☐	Critical Incident Stress Debriefing (CISD)	☐
Hazmat Awareness Level Training	☐	Incident Command Structure (ICS)	☐
Pediatric Advanced Life Support (PALS)	☐	Unified Command Structure (UCS)	☐
WMD Awareness Level Training	☐	American Red Cross	☐
Disaster Medical Assistance Team	☐	Disaster Mortuary Operational Response Team (DMORT)	☐

Other Certifications or Training:

How did you learn about the Medical Reserve Corps?

PLEASE INDICATE YOUR AVAILABILITY FOR TRAINING						
Sunday	Mornings	☐	Afternoons	☐	Evenings	☐
Monday	Mornings	☐	Afternoons	☐	Evenings	☐
Tuesday	Mornings	☐	Afternoons	☐	Evenings	☐
Wednesday	Mornings	☐	Afternoons	☐	Evenings	☐
Thursday	Mornings	☐	Afternoons	☐	Evenings	☐
Friday	Mornings	☐	Afternoons	☐	Evenings	☐
Saturday	Mornings	☐	Afternoons	☐	Evenings	☐

EMERGENCY CONTACT INFORMATION		
Name:		Relationship:
Address:		
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell Phone:
Name:		Relationship:
Address:		
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell Phone:
Name:		Relationship:
Address:		
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell Phone:

REGISTRATION INFORMATION CONTINUED ON NEXT PAGE

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HEALTH INFORMATION

Describe restrictions on activities:

List all medications, vitamins, herbs and OTC drugs:

Are you allergic to any medication? Yes ☐ No☐

List medications that you are allergic to:

Please check if you have other allergies such as pollen, molds, etc. ☐

Do you give permission to contact your emergency contact person if necessary? Yes ☐ No☐

Comments/Recommendations

☐	Anthrax Date of Last:	☐	Diptheria
☐	DTaP	☐	Hepatitis A
☐	Hepatitis B (series)	☐	Influenza Date of Last:
☐	Meningococcal Meningitis	☐	MMR
☐	Polio	☐	Rotavirus
☐	Smallpox	☐	Tetanus Date of last:
☐	Typhoid	☐	Varicella
☐	Yellow Fever Date of Last:		
☐	Tb test Date of Last Tb test:		Tb Due Date:

The Medial 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 this 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. **I understand to be covered by liability that I must be registered in the state MRC database, therefore I give my permission.** The Medical Reserve Corps reserves the right to disqualify or reject any volunteer.

Signature of Registrant:	Date