



**MEDICAL RESERVE
CORPS VOLUNTEER
APPLICATION**



CONTACT INFORMATION

NAME: First _____ Middle Initial _____ Last _____
ADDRESS: Street _____ City/Town _____ Zip code _____
PHONE: Home _____ Cell _____ Work _____
EMAIL: _____ Date of Birth: _____ Gender _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: _____

LANGUAGE SKILLS

Primary: _____ Speak & Understand Read & Translate Write
Other: _____ Speak & Understand Read & Translate Write
Are you fluent in American Sign Language? Yes No
Would you be willing to work as an interpreter in an emergency? Yes No

CURRENT OCCUPATION

Organization: _____
City/State: _____
Position title: _____
Work status: Full-time Part-time Student
 Consultant Retired Other

OTHER PROFESSIONAL/VOLUNTEER EXPERIENCE

Organization: _____
Address: _____
Position title: _____
Dates: from _____ to _____

WHAT WILL YOU VOLUNTEER FOR?

Emergencies only Emergencies and non-emergencies (e.g., flu clinics, health fairs)
 Local Regional State-wide Federal

HEALTH

Have you been immunized against smallpox? Yes No
Do you have any special needs or restrictions? If so, please explain. _____

DISASTER SERVICES TRAINING/EXPERIENCE

Have you had disaster services training (other than CPR or First Aid)? No

Yes, description _____

Have you had prior experience with disaster/crisis response? No

Yes, description _____

Please check off any Federal Emergency Management Agency (FEMA) courses you have taken:

Incident Command System 100 Incident Command System 200 Incident Command System 300

Incident Command System 400 National Incident Management System 700

National Incident Management System 800 Other, please explain _____

PROFESSIONAL LICENSES AND CERTIFICATIONS

<input type="checkbox"/> Medical license: Type _____ State _____ Number _____ Expiration _____	<input type="checkbox"/> Nursing license: Type _____ State _____ Number _____ Expiration _____	<input type="checkbox"/> EMT/Paramedic license: Type _____ State _____ Number _____ Expiration _____	<input type="checkbox"/> Other license: Type _____ State _____ Number _____ Expiration _____
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<input type="checkbox"/> Certificate Description _____ Expiration _____	<input type="checkbox"/> Certificate Description _____ Expiration _____
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Do you have prescriptive authority? No Yes

Do you have CPR Certification? No Yes, expiration date _____

Are you first aid certified? No Yes, expiration date _____

Are you AED certified? No Yes, expiration date _____

Have you ever had your professional license suspended or revoked? No Yes (Please attach letter of explanation)

WHEN ARE YOU AVAILABLE?

Weekdays

- Daytime (8am- 4pm)
- Evenings (4pm- 12am)
- Overnight (12am- 8am)

Weekends

- Daytime (8am- 4pm)
- Evenings (4pm- 12am)
- Overnight (12am- 8am)

Do you hold any other positions, paid or volunteer, that require your attendance during an emergency? Yes No If yes, please explain _____

SPECIALTY UNIT TEAMS

Would you be interested in being on one or both of the following specialized teams?

Virtual Operations Support Team Yes No

The Region 4 VOST analyzes social media to help emergency responders identify unmet needs and better manage their resources for the benefit of the whole community. Team members must be proficient in various social media platforms such as Facebook and Twitter before completing our two-day VOST training.

What platforms do you use regularly?

Facebook Twitter Instagram Pinterest Scope Periscope
Tweetdeck Hootsuite Yelp Other

Cable Access Television Show Yes No

Crew members work with cameras and recording equipment at a Norwich studio to tape segments of the Uncas Health District's monthly television show called "Public Health Matters." The show features speakers discussing various health related topics. No previous experience is necessary- training is provided.

CONVICTIONS

Within the last 10 years, have you been convicted of any felony or misdemeanor offense, in Connecticut or in any other state or place, including entering a plea of nolo contendere or no contest, including any conviction which has been expunged? Yes No

Are there any criminal charges currently pending against you? Yes No

If you answered yes to either of these questions, attach a detailed statement describing the crime(s), date, location, court, sentence served, and applicable parole.

PHOTOGRAPHS

I do not object to the MRC taking photos of my likeness during training/activation and potentially using the images in training and outreach materials. I understand it is my responsibility to alert the photographer if I object to the taking of my photo. *Initial here* _____

ACKNOWLEDGEMENT

I attest that to the best of my knowledge, the information provided on this application is accurate, I understand that it is my responsibility to notify my MRC unit of any circumstances that affect the accuracy of the information I am providing. By checking below, I agree to allow the Medical Reserve Corps to verify the above information and understand that a more comprehensive background check may be required. I understand that any incorrect, incomplete, or false information on this application could result in rejection of my application.

I understand that this information will be contained in a central, secure database administered by the Uncas Health District for purposes of contacting me in case of a declared state of emergency, or for preparedness or other public health activities. Depending on need and availability, although I have volunteered, I understand that I may not be asked to participate in all activities.

I understand that I retain the right to refuse to volunteer for any reason.

I understand that I will not receive compensation nor be paid for any services I render. I further understand that I am not able to bill any individual, organization, or business for services I render while acting in the capacity of a volunteer for the Medical Reserve Corps.

I understand that it is my responsibility to coordinate my volunteer time with my employer or non-paid obligations relative to emergency response (e.g., DMAT) if the time I have been asked to volunteer conflicts with my work schedule and/or emergency response obligations.

I agree to abide by any and all confidentiality protocols at the agency, institution or designated emergency site where I am assigned, as communicated to me by the supervisor in charge.

I agree to maintain all patient-related information to which I have access to. Including but not limited to protected health information, in the strictest confidence in accordance with all applicable laws and regulations. Without limiting the foregoing, I will comply with the confidentiality and disclosure requirements of applicable law and regulations, including but not limited to laws and regulations regarding the release of information pertaining to treatment of mental illness, substance abuse, and HIV testing and results, and the Health Insurance Accountability and Portability Act of 1996 ("HIPPA").

I agree to abide by the protocols of the MRC unit as well as the agency, institution or designated emergency site where I am assigned, as communicated to me by the supervisor in charge.

Please check the box below to confirm this acknowledgement:

I agree to the above statement

WAIVER AND RELEASE

I recognize that participation as a volunteer in the Medical Reserve Corps program may carry a risk of personal injury.

I further recognize that there are natural and man-made hazards, environmental conditions, diseases and other risks, which, in combination with my action can cause injury to me, particularly in a disaster situation. I hereby agree to assume all risks, which may be associated with or may result from my participation in the program. I further recognize that these program activities will involve physical activity and may cause physical and emotional discomfort. I state that I am free from any serious health problems that could prevent me from participating in any activities associated with the program.

I recognize that as a volunteer, I will be entitled to the liability protections afforded by Sections 4-165 and 5-141d of the Connecticut General Statutes, to the extent provided in Public Act 03-236. As part of my participation in the Medical Reserve Corps program, I understand that the State of Connecticut has agreed to ensure professional liability coverage and workers' compensation coverage for my work in connection with the program, provided that I take the loyalty oath once every two years as required by the State statute for the cost of any emergency or other medical care that I receive that is not covered under applicable workers' compensation benefits.

I agree to release and hold harmless the State of Connecticut and its subdivisions, the Uncas Health District, the Medical Reserve Corps and any hospital, facility, institution or agency at which I volunteer in connection with the program, as well as each of their respective officers, employees and agents from any and all liability, claims, demands, actions, and causes of actions whatsoever for any loss claim, damage, injury, illness, attorney's fees or harm of any kind or nature to me out of any and all activities associated with my participation in the program.

I have read and understand all of the information regarding my participation in the Medical Reserve Corps program.

I have read and understand the above waiver and release and agree to all provisions above.

Thank you for your interest.

Signature _____ **Date** _____

Print Name _____

Please RETURN the completed form to:

Medical Reserve Corps
C/O Uncas Health District
401 West Thames Street, Suite 106
Norwich, CT 06360-5450

Or email to: aschulz@qualityperspectives.com
Telephone: 860-823-1189

For Office Use:

Date: _____

Initial: _____