

Southern Strafford County Medical Reserve Corps Volunteer Application Form

Please print the application and then mail to the address on the last page of this form.

Thank you for your interest in volunteering, please complete the following Volunteer Application Form and return to Southern Strafford County Health Coalition (contact information located on the last page).

Contact Information:

First Name: _____ Last Name: _____

Street Address: _____ City/Town: _____ State: _____

Zip code: _____ Date of Birth: _____ (mm/dd/yyyy)

Mailing Address (if different from above): _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Email: _____

Work Phone: _____ Other number: _____

How would you like us to contact you? (Please circle one) Home Phone Email Cell

Professional Information:

Work Status: (Please circle one) FT PT Ret.

Employer: _____ Address: _____

Phone Number: _____ Contact: _____

Medical License 1: type: _____ Number: _____

Issue Date: _____ (mm/dd/yy) Exp Date: _____ (mm/dd/yy)

Medical License 2: type: _____ Number: _____

Issue Date: _____ (mm/dd/yy) Exp Date: _____ (mm/dd/yy)

Medical License 3: type: _____ Number: _____

Issue Date: _____ (mm/dd/yy) Exp Date: _____ (mm/dd/yy):

Check your profession/occupation (all that apply):

__Physician: MD __DO__

__Physician Assistant__

__Nurse: RN __LPN __LNA__

__Nurse Practitioner

__EMT: Paramedic __Intermediate __Basic __

__Educator (health/other)

1st Responder __

__Behavioral Health: Psychologist __ LSW__LADAC__

__Admin. Support

__Pharmacy: Pharmacist __Pharmacy Tech__

__Therapist:_____

__Dental: Dentist __Dental Assistant __ Hygienist__

__Other: _____

__Laboratory: Medical Technologist__

__Veterinary: Veterinarian__ Vet. Tech_____

Are you First Aid Certified? YES____ NO____ If yes, expires _____ (mm/dd/yy)

Are you CPR Certified? YES____ NO____ If yes, expires _____(mm/dd/yy)

Do you have teaching experience? YES____ NO____ If yes, how long? _____

Are you part of any other emergency/disaster response team or alert system? YES__NO____

If yes, please list:

Have you registered with ESAR VHP? YES___ NO___

Other Information:

Do you have a current New Hampshire's Drivers' License? YES___ NO___

Drivers License #: _____ State Issued: _____ Exp Date: _____

Would you be interested in leadership positions within the MRC? YES___ NO___

Please choose one of the following volunteer opportunities that best describes how you would like to participate in the MRC Program.

_____ MRC Basic Member

1. Activated only in case of a local emergency
2. Notified of trainings and drills

_____ MRC Active Member

1. Activated for local emergencies
2. Called to help with special projects and events
3. Notified of trainings and drills

_____ MRC Team Leader Member

1. Activated for local emergencies
2. Called to help with special projects and events
3. Notified of trainings and drills
4. Administrative and clerical duties

Please circle your availability. Circle all that apply.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Mornings		Afternoons		Evenings		Anytime

Emergency/Contact & Medical Information: (optional)

Emergency Contact: _____ (First, M.I, Last)

Relationship: _____

Address: _____

Home Phone: _____

Other number: _____

Medical conditions or information we should know about: (optional)

Allergies:

Do you carry an EpiPen? YES _____ NO _____

Do you carry a Glucometer? YES _____ NO _____

References

Please list two personal references that are not related to you.

Name: _____ Address: _____

Phone: _____ Relationship: _____

Name: _____ Address: _____

Phone: _____ Relationship: _____

All of the information that I have supplied is correct to the best of my knowledge. I do hereby give my local Medical Reserve Corps (MRC) permission to make inquiries concerning my educational background, references, driving record, present and previous employment, licenses, certifications and police record. I further give permission to the holder of any such records to release the same to the MRC. I hold the MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of the information about me. I also hold harmless any individual, agency, business or corporation that provides information to the MRC. I recognize that I should investigate my personal and business liability coverage as pertains to

my volunteer work for the MRC. I recognize that prior to being accepted as a MRC volunteer, I may be required to provide additional documentation as proof of certain certifications (CPR, First Responder, CDL, etc.)

I understand that I am a volunteer and will not be paid for any of my services.

I give my permission for the MRC to release personal information to local, state and federal emergency management agencies and other Health and Human Service agencies as needed.

Be sure this _____ is checked if you accept these terms.

Signature

Date

Martha Swats, MRC Director

Southern Strafford County Health Coalition

Southern Strafford County Medical Reserve Corps

259 County Farm Rd Unit 5

Dover, NH 03820

(603) 516-7187

sscmrcnh@gmail.com