

Medina County Medical Reserve Corps  
**VOLUNTEER REGISTRATION**



Please print clearly.

Today's date \_\_\_\_\_

**Personal Contact Information**

Title: Dr. Mrs. Ms. Mr. PhD. Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County of Residence \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Mobile Phone (\_\_\_\_) \_\_\_\_\_

Email Address *\*(required)* \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender:  Male  Female

Social Security Number (optional) \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Driver's License Number *\*(required)* \_\_\_\_\_ State Issued *\*(required)* \_\_\_\_\_

DL Expiration Date *\*(required)* \_\_\_\_\_

**Work Contact Information**

Occupation \_\_\_\_\_ Specialty \_\_\_\_\_

Full time  Part time  Retired  Student

Professional License Current? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ NA State(s) where licensed to practice \_\_\_\_\_

License/Certification # *\*(required)* \_\_\_\_\_ Expiration Date \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone, Ext \_\_\_\_\_

Work Fax (\_\_\_\_) \_\_\_\_\_

Are you an employee of a local health department?  Yes  No If so, which one? \_\_\_\_\_

What is the highest level of education you have completed? \_\_\_\_\_

Are you interested in volunteering for future events?  Yes  No

*\*This information is required for State database entry*

## 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"/> DD 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                       |

No preference. You may call on me for any emergency.

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 experience?  Yes  No If so, describe \_\_\_\_\_

## Previous Training

Please check all current 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)         | Other Certifications or training: _____                              |
| <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               |  |



**Availability**

Are you part of an emergency/disaster plan with another organization?  Yes  No

Circle those you are a part of:

American Red Cross

United Way

CERT (which community): \_\_\_\_\_

Other: \_\_\_\_\_

Are you willing to attend the mandatory Medical Reserve Corps training? (4 hours)  Yes  No

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 |

Have you ever been convicted of a felony?  Yes  No

Have you ever been convicted of a misdemeanor?  Yes  No

Are you willing to submit to a background check if position merits?  Yes  No

**Do you give permission to add your information to the Ohio Medical Reserve Corps (OMRC) Statewide Data Base System?**  Yes  No [[www.serveohio.org](http://www.serveohio.org)]



Medina County Medical Reserve Corps  
**VOLUNTEER HEALTH INFORMATION FORM**

Please print clearly.

Today's date \_\_\_\_\_

**Personal Contact Information**

Describe any restrictions you have on activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications, vitamins, herbs, and over the counter drugs you usually take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies or other medical conditions that a physician would need to be aware of:

\_\_\_\_\_

\_\_\_\_\_

Please circle any vaccines you have received below :

Anthrax #1 #2 #3 #4 #5 #6 Booster (date) \_\_\_\_\_ Polio MMR #1 #2  
Smallpox (date) \_\_\_\_\_ Hepatitis A #1 #2 Tetanus (date) \_\_\_\_\_  
Hepatitis B series #1 #2 #3 Typhoid (date) \_\_\_\_\_ Influenza (date) \_\_\_\_\_  
Meningococcal (date) \_\_\_\_\_ Yellow Fever (date) \_\_\_\_\_ Tb skin test (date) \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone Number ( ) \_\_\_\_\_ Evening/Cell Phone Number ( ) \_\_\_\_\_

May we call your emergency contact person in the event of an emergency?  Yes  No



The Medina County Health Department 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 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 Medina County Health Department reserves the right to disqualify or reject any volunteer.

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return this form to:

Jessica Miles, M.Ed., CHES  
Medina County Medical Reserve Corps Coordinator  
[jmiles@medinahealth.org](mailto:jmiles@medinahealth.org)

Medina County Health Department  
4800 Ledgewood Drive  
Medina, Ohio 44256  
(330) 723-9688, ext. 639  
or  
Fax (330) 723-9659



For Office Use Only:
Date sent to volunteer: _____
Date received: _____
Date entered into database: _____