



GREATER TAUNTON MEDICAL RESERVE CORPS

Volunteer Application Form

1. Demographic Information:

| | | |
|------------------------------|------------------------|----|
| Last Name | First Name | MI |
| Primary Area of Employment | | |
| Employer (Former if Retired) | | |
| Drivers License/Class/State | Gender: Male Female | |

2. Contact Information:

| | |
|--|---------------|
| Mailing Address Street Number Street Name Apt # City State Zip Code | |
| Home Address (if different from above) Street Number Street Name Apt # City State Zip Code | |
| Primary Email Address Alternate Email Address | |
| Daytime Phone | Evening Phone |
| Mobile Telephone | Pager |

3. Emergency Contact:

| | | | |
|--------------|----------|--------------|----------|
| Name | Relation | Name | Relation |
| Address | | Address | |
| Phone Number | | Phone Number | |

4. Personal Health (for purpose of assigning appropriate positions)

| |
|--|
| Please list any health problems or physical restrictions: _____ _____ _____ Are adaptations required? _____ _____ _____ |
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For Volunteers with clinical training/licensure, please review and complete the following section indicating appropriate title and/or occupation listed. All other Volunteers may skip to section 6.

5. Occupation/Background (Please check all that apply)

| | |
|--|---|
| <input type="checkbox"/> Counseling/Mental Health | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Pharmacy Technician |
| <input type="checkbox"/> Epidemiology | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Epidemiology (Nurse) | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> EMT/Paramedic | <input type="checkbox"/> Toxicologist |
| <input type="checkbox"/> Lab Technician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Vet Tech |
| <input type="checkbox"/> Nurse (Clinical Specialist) | <input type="checkbox"/> Non-clinical Staff |
| <input type="checkbox"/> CNA, LPN | <input type="checkbox"/> Police Officer |
| <input type="checkbox"/> Fire Fighter | <input type="checkbox"/> Environmental Services |
| <input type="checkbox"/> Clinical/Medical Student (please specify school, program of study, and graduation date) _____ | |
| <input type="checkbox"/> Other _____ | |

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| <p>Please indicate any applicable degrees (i.e. MD, RN)</p> <p>Are you currently licensed and/or certified to practice in Massachusetts? Copies Required.</p> <p><input type="checkbox"/> Yes Licensing Agency: _____ License # _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Have you ever had your professional license suspended or revoked? Circle one: Yes, letter of explanation attached. No</p> <p>Please indicate any affiliation with health care organization (hospital, health center, visiting nurse association) _____</p> <p>Other Licenses/Certifications _____</p> <p>Please list any other affiliations that you are associated with: _____</p> <p>_____</p> |
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6. Skills/Areas of Expertise (check all that apply)

| | | |
|----------------------------------|-----------------------|--------------------------|
| Case Management (Non-Clinical) | Driver/Delivery | Media/Public Relations |
| Clinical/Nursing Case Management | Events Organizer | Mental/Behavioral Health |
| Child Care Provider | Food Preparer | Outbreak Investigation |
| Communications | Fund raising | Patient Advocacy |
| Communicable Disease | Hazardous Materials | Phlebotomy |
| Community Organizing | Health Education | Phone Bank |
| Compassionate Provider | Home Visiting | Provider Education |
| Counseling | Inspection | Public safety |
| Crisis intervention | Interviewing | School Health |
| Customer Service | Logistics | Triage |
| Data Analysis | Materials Management | Vaccination |
| Data Entry | Maternal/Child Health | |

7. Languages: Please indicate languages spoken and circle level of proficiency.

| Language | Speaking | Reading | Writing | Medical Interpretation |
|---------------------------|------------------|------------------|------------------|------------------------|
| 1) | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair |
| 2) | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair |
| 3) | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair |
| 4) American Sign Language | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair | Fluent Good Fair |

8. Levels of Involvement. Please indicate the level you are interested in:

| |
|--|
| <p>___ Response/Inactive Level: Response Level involves a minimal time commitment. Members are only asked to volunteer in the event of a mass emergency. You are required to complete two 1½ hour trainings, which can be done in person or online. If activated, volunteers will receive training specific to the event before being assigned to a deployment.</p> |
| <p>___ Active Level: Active Level involves slightly more time commitment. In addition to the initial mandatory trainings you plan to attend other trainings of your choice. A minimum of two trainings/meetings a year is required to maintain active level. If activated, volunteers will receive training specific to the event before being assigned to a deployment.</p> |
| <p>___ Leadership Level: Leadership Level is open to those who want a role in management of a clinic or a part of a clinic. There is a larger training commitment, requiring 10-15 hours of training in addition to the initial orientation. You may also want to be involved in your local chapter at the council level. If activated, volunteers will receive training specific to the event before being assigned to a deployment.</p> |

9. References: Please provide 2 references. For licensed applicants, at least 1 professional reference is preferred from a current or previous employer or colleague.

| | |
|---------------|-------------|
| Name _____ | Phone _____ |
| Address _____ | Email _____ |
| _____ | _____ |
| Name _____ | Phone _____ |
| Address _____ | Email _____ |
| _____ | _____ |

| | |
|---|------------------------------------|
| <u>How did you hear about the Greater Taunton Medical Reserve Corps?</u> | |
| a) Brochure _____ | b) Friend or colleague _____ |
| c) Website _____ | d) Professional organization _____ |
| e) Other _____ | |

**Volunteer Consent for References, Background Checks,
Release of Information and Media Waiver**

I understand that the information on this application will be kept confidential. I do hereby give the Greater Taunton Medical Reserve Corps. permission to inquire into my background, including references, employment, licensure, driving record, police record, education and/or volunteer history as part of the verification/application process. I further give permission to the holder of any such records to release the same to the GTMRC. Additionally, I do hereby consent to the release of personal information to local, state and federal emergency management and other Health and Human services agencies as needed. I further understand I will be required to sign a CORI request form. I understand that as a Medical Reserve Corps volunteer I am not paid for my services. I further understand that I will be required to sign a Code of Conduct upon approval of my application and that the MRC may develop, participate in or be the subject of media based presentations and events and give my permission to publish my name and photograph with any MRC activity. I hereby hold the MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of information about me. I further hold harmless any individual, agency, business or corporation that provides documents to the MRC.

Assumption of Risk

I recognize that the Volunteer Medical Corps may involve physical labor and may carry a risk of personal injury. I further recognize that there may be natural and manmade hazards, environmental conditions, diseases and other risks, which in combination with my actions could cause injury to me. I hereby agree to assume all risks, which may be associated with or may result from my participation in this volunteer program.

Release

I hereby release the "Hosting Community", its agencies, departments, officers, employees, agents and assigns, from any and all liability, claims, demands, actions, and causes of action whatsoever for any loss claim, damage, injury, illness, attorney's fees or harm of any kind or nature to me arising out of any and all activities associated with this volunteer program.

Signature of Volunteer _____ **Date** _____
Printed Name _____

Thank you for your interest in the Greater Taunton Medical Reserve Corps

Please mail this form to the address below:

**TAUNTON BOARD OF HEALTH
ATTN: MARC CORREIA
45 SCHOOL STREET
TAUNTON, MA 02780**