

Greater Portsmouth Region Medical Reserve Corps

Volunteer Application



Please print clearly

Personal Contact Information

Dr. Mrs. Mr. Ms. (Circle one)

Last Name: _____ First Name _____ MI: _____

Home Address: _____ Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____ Personal Pager: _____

In case an emergency happens to me please contact: _____

Name: _____ Relationship: _____

Daytime phone #: _____ Evening Phone #: _____

Although the focus of our unit is on local emergencies, would you like us to call you in case of a statewide or national emergency (such as Hurricane Katrina relief efforts in 2005)? *Please circle all that apply.*

National

Statewide

Greater Portsmouth Region

If volunteers are need for response to an emergency during the hours when you'd be working, is it OK to contact you at your place of employment? **YES** **NO**

If YES, please provide the following information:

Occupation: _____ (circle) Full-time Part-time Retired Student

Employer: _____ Address: _____

Phone # & Ext: _____ Fax: _____

In the event that volunteers are called upon to respond to an emergency: Please list additional person(s) who may be used to contact you if we are unable to reach you using the information provided above:

Contact: _____ Phone #: _____ Relationship: _____

Education

Education: (check highest level) High School College Graduate School Other

School Name: _____ Location: _____

Type of Degree: _____ Major/Specialization _____ Yr. Graduated: _____

License (Professionals with a current license or certification in any health or mental health field)

Circle all applicable

License/Certification #

Expiration Date:

1. M.D./D.O.

2. D.V.M./V.M.D

3. D.D.S./D.M.D

4. D.C.

5. R.N.

6. L.P.N.

7. EMT/Paramedic

8. P.A./N.P.

9. Pharmacist

10. Psychiatrist/Psychologist

11. Other Mental Health Practitioner

12. Social Work LSCSW LMSW LBSW

13. Other health related degrees or licenses

14. Do you have prescriptive authority? Yes No

Please attach a copy of your current professional license to this application.

Certifications & Training (Check all that apply)

Certifications

Most Recent Date

Certifying Agency

CPR

First Aid

Disaster Training

CERT

Bloodborne Pathogens &
Standard Precautions

Military Medical Training

Training (check any that you have attended)

- Incident Command System (NIMS 100/200/700)
- Epidemiology
- Bioterrorism
- Terrorism & Emergency Response to Terrorism
- Other

Skills

What languages do you **speak** or understand other than English? Please list and indicate level of fluency:

Languages Spoken (Include sign language)	Level of fluency (circle one)			Read	Write
	Excellent	Fair	Poor	Yes	No
_____	Excellent	Fair	Poor	Yes	No
_____	Excellent	Fair	Poor	Yes	No

Please list any other special skills you bring to the Medical Reserve Corps.

Areas of Interest Indicate your areas of interest by checking below (you may check more than one area)

During an Emergency (At a mass vaccination/pharmaceutical distribution site, acute care center, etc.)

Licensed Volunteers

- Assist with vaccinations
- Pharmaceutical distribution
- Mental Health Consultant
- Medical Screening
- Staffing Shelters

Non-Licensed Volunteers

- Greet Patients
- Register Patients
- Educate patients (vaccination/antibiotics)
- Assist with communication (HAM radio)
- Assist with clinic/shelter flow
- Language interpreter/translator
- Supply/Stock Manager

Availability Indicate times when you are available to volunteer (for non-emergencies)

	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday
<i>Circle all that apply</i>	Morning	Morning	Morning	Morning	Morning	Morning	Morning
	Noon	Noon	Noon	Noon	Noon	Noon	Noon
	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
	Evening	Evening	Evening	Evening	Evening	Evening	Evening

Do you have any personal health issues that would impact your ability to volunteer? Yes No

(For example: allergies, medication issues, disabilities, special needs, or being treated for a medical condition). If yes, please either list here or speak personally with the MRC coordinator.

As a Greater Portsmouth Medical Reserve Corps volunteer, I understand that I may be called upon during a public health emergency. I certify that the above information is correct.

Signature

Date

Please return the completed application form to:

Kim Coffey-Philbrick
Portsmouth Health Department
1 Junkins Avenue
Portsmouth, NH 03801

For more information:

Kim Coffey-Philbrick, RN, BS
Public Regional Health Nurse
603-610-7302
mrc@cityofportsmouth.com

T-Shirt Size

Women *Circle One* S M L XL XXL

Men *Circle One* S M L XL XXL