

Ashtabula County Medical Reserve Corps  
**VOLUNTEER REGISTRATION**



Please print clearly.

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

**Personal Contact Information**

Title: Dr. Mrs. Mr. Ms.      **Are You Interested in Volunteering for future Events?** Yes    No

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

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

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

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ ext \_\_\_\_\_

Mobile Phone ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Email Address \_\_\_\_\_

**Work Contact Information**

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

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

Full time     Part time     Retired     Student    License/Certification # \_\_\_\_\_

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

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

Birth date \_\_\_\_\_ Place of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female

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

Driver's License Number \_\_\_\_\_ State Issued \_\_\_ DL Expiration Date \_\_\_\_\_

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? \_\_\_\_\_

**Emergency Contact Information**

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

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

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

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

Do you speak or read a language other than English?  Yes  No If so which one? \_\_\_\_\_

Do you have any disaster or crisis training or 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"/> Advanced Trauma Life Support (ATLS) |
| <input type="checkbox"/> American Red Cross                          | <input type="checkbox"/> Basic Cardiac Life Support (BCLS)   |
| <input type="checkbox"/> Basic Disaster Life Support (BDLS)          | <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"/> Disaster Medical Assistance Team    |
| <input type="checkbox"/> Disaster Mortuary Operational Response Team | <input type="checkbox"/> Hazmat Awareness Level training     |
| <input type="checkbox"/> Incident Command Structure (ICS)            | Other Certifications or training: _____                      |
| <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 trainings?  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



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

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

\_\_\_\_\_  
Date

Please return this form to:

Libby Holden  
Ashtabula County Medical Reserve Corps Coordinator  
lholden@ashtabulacountyhealth.com

Ashtabula County Health Department  
12 W Jefferson St  
Jefferson, Ohio 44047  
(440) 576-3023, ext. 115  
or  
Fax (440) 576-0001



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

