Northwest Illinois Medical Reserve Corps
Volunteer Application

Please print clearly

Personal Contact Information

Dr. Mrs. Mr. Ms.

Last Name____________________________ First Name_________________________ MI _____ (Circle one above)

Home Address: ____ Apt. # _____________

City _________________________________ State____________________ Zip Code ____________

Home Phone #_________________ Cell Phone # __________________ Work Phone # __________________

E-mail Address _______________________________ Cellular Provider ______________________________

In case an emergency happens ***to me*** please contact:

Name: ____ Relationship: _____________________________________

Phone number: ________________________

Are you 18 years of age or older? ☐ Yes ☐ No

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 any that apply:

National **Statewide** **Neighboring County** **County** **Town**

If volunteers are needed 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 _____________________________________ (check) ❑ Full Time ❑ Part Time ❑ Retired ❑ Student

Employer___________________________________ Address ____

General Phone Number (____)__________Your extension _________________ Fax #(____)________________

Driver's License #:____________________ State:__________ Type:______ Restrictions:__________________

Education

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

School Name:________________________________ Location: ________________________________

Type of Degree:____________________ Major/Specialization:__________________ Year Completed:______

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 any that apply)

Certifications **Most Recent Date** **Certifying Agency**

- ❑ CPR ______________________________
- ❑ First Aid ______________________________
- ❑ Disaster Training ______________________________
- ❑ CERT ______________________________
- ❑ Bloodborne Pathogens & Standard Precautions ______________________________
- ❑ Military Medical Training ______________________________

Training (Check/circle any that you have attended)

- ❑ Incident Command System100/200 other
- ❑ NIMS-700
- ❑ Epidemiology
- ❑ Bioterrorism
- ❑ Terrorism & emergency response to terrorism

❑ Other Training (list below)

____

____

____

____

____

Skills

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

Languages spoken:	level of fluency (*circle one*)			Read and write?	
______________	**Excellent**	**Fair**	**Poor**	**Yes**	**No**
______________	**Excellent**	**Fair**	**Poor**	**Yes**	**No**

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

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

<u>During an Emergency</u> (At a mass vaccination or pharmaceutical distribution site or shelter)

Licensed volunteers

- ❏ Assist with vaccinations
- ❏ Pharmaceutical distribution
- ❏ Medical screening
- ❏ Mental health consultation
- ❏ Staffing shelters

Non-licensed volunteers

- ❏ Greet patients
- ❏ Register patients
- ❏ Educate patients (on the vaccination procedure)
- ❏ Language interpreter/translator
- ❏ Public Information contact
- ❏ Computer support
- ❏ Assist with clinic/shelter flow
- ❏ Forms completion and collection
- ❏ Data Entry
- ❏ Supply/Stock Manager
- ❏ Clinic/shelter Manager
- ❏ Other logistics support
- ❏ Other as needed

<u>Non-Emergency Opportunities</u> (Check your preferences)

Work Directly with Patients/Clients

❏ Assist with Flu Clinics ❏ Provide patient education
❏ Assist patients with forms ❏ Language interpreter/translator

Provide Indirect Support (little or no patient/client contact)

❑ Provide health program assistance

❑ Computer support

❑ Clerical assistance

❑ Medical Records assistance

❑ Provide education and/or presentations on health topics *(check topics of interest or list your expertise)*

❑ Diabetes ❑ Prescriptions/ pharmacy

❑ Obesity/ healthy lifestyles ❑ Smoking cessation ❑ ____

Other topics____

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

Circle all that apply

❑ Monday	❑ Tuesday	❑ Wednesday	❑ Thursday	❑ Friday	❑ Saturday	❑ Sunday
Morning Noon Afternoon Evening	Morning Noon Afternoon Evening	Morning Noon Afternoon Evening	Morning Noon Afternoon Evening	Morning Noon Afternoon Evening	Morning Noon Afternoon Evening	Morning Noon Afternoon Evening

How did you learn about the Medical Reserve Corps?

____

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.

____

I hereby certify the information I have supplied above is true and accurate, that I am freely volunteering for such duty without coercion or duress, and that I am mentally and physically fit for service. I understand the information that I have supplied may be disclosed for security reasons. I understand that I may be assigned to a variety of duties, but that every reasonable effort will be made to find a good match with my interests and skills. I understand this is a totally volunteer effort and I will not be paid for my services.

By signing, you are also giving consent for the Stephenson County Health Department to inquire into my educational background, licenses, police records, and employment/volunteer history.

____ ____________

Signature of applicant Date

Please return application to:

Bobbie Bahr, MRC Coordinator 10 W Linden St, Freeport, IL 61032 Bbahr@stephensoncountyil.gov

STEPHENSON COUNTY HEALTH DEPARTMENT
WRITTEN NOTICE AND AUTHORIZATION TO RELEASE INFORMATION
REGARDING PROCUREMENT OF A CONSUMER REPORT

In connection with your employment or your application for employment, we may procure a consumer report or an investigative consumer report on you as part of the process of considering your candidacy as an employee. In the event that information from the report is utilized in whole or in part in making an adverse decision with regards to your potential employment, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the federal Fair Credit Reporting Act. The FCRA gives you specific rights in dealing with consumer reporting agencies. You will be given a summary of these rights together with this document.

By signing below, I ______________________________ hereby authorize and direct you to release to: Stephenson County Health Department, or their designee, any "consumer reports" about me from a "consumer reporting agency" and to consider the "consumer reports" when making my employment decision. I understand I have rights under the Fair Credit Reporting Act, including the rights discussed above.

I hereby release any and all information in your files pertaining to birth, education, employment, credit, criminal history, medical records, workers compensation claims and driver's license abstracts, including, but not limited to academic achievements, attendance, personal history, disciplinary records, medical, credit records and criminal convictions. I hereby release and absolve you as custodian of such records of any school, college or other state or educational institution, hospital, clinic or any other repository of medical records, credit bureau, lending institution, consumer reporting agency, police or sheriff's department or retail business. This release would include its officers, employees or related personnel, both individually and collectively from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family or associates because of compliance with this authorization or any attempt to comply with it.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original signature. Should there be any question as to the validity of this release, you may contact me as indicated.

***** **PLEASE PRINT CLEARLY** *****

FULL NAME : ____
FIRST MIDDLE LAST

OTHER NAMES USED : ____
FIRST MIDDLE LAST

CURRENT ADDRESS : ____
STREET CITY STATE/ZIP

PREVIOUS ADDRESS : ____
STREET CITY STATE/ZIP

COUNTIES LIVED IN THE PAST TEN (10) YEARS : ______________________________

HOME PHONE : ______________________________

The following information must be completed for the sole purpose of searching Criminal Records, Credit History, SSN Verification, Motor Vehicle Driving Records or Worker's Compensation Records.

DATE OF BIRTH : ______________ SOCIAL SECURITY NUMBER : ______________________

DRIVER'S LICENSE NUMBER : ______________________ STATE ISSUED: ____________

SIGNATURE : ______________________________ **DATE/TIME :** ______________