

MEDICAL RESERVE CORPS VOLUNTEER APPLICATION
Licking County Health Department

Please complete the following volunteer application. If you need extra space, please feel free to attach pages or to continue on the back of the page. Please print.

Check One:

I am interested in being a part of the MRC. (complete entire application)

I am not interested in being a part of the MRC. (complete section 1 only)

Section 1: Personal Information

Name: _____

Address: _____

City: _____ State: Ohio Zip: _____

Phone: _____ Cell: _____

E-mail Address: _____

Section 2: Education/License

Degree: _____

Institution: _____ Dates Attended: _____

License Held: _____ Expiration Date: _____

License Number: _____ Pending Action? Y _____ N _____

License Held: _____ Expiration Date: _____

License Number: _____ Pending Action? Y _____ N _____

Section 3: Professional Skills

Occupation: _____ Employer: _____

Address: _____ Phone: _____

City: _____ State: Ohio Zip: _____

Special Skills: _____

Languages spoke: _____

Section 4: Experience (paid and volunteer beginning with most recent)

<u>Position</u>	<u>Organization</u>	<u>Dates</u>
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Section 5: Volunteering Preferences

Availability (days and hours): _____

Are you interested in volunteering in times of disaster: Y_____ N_____

Are you interested in volunteering with community betterment education and prevention programs throughout the year: Y_____ N_____

Are you available for the necessary disaster response training, such as disaster response training or opportunities for continuing education credits?
Y_____ N_____

Section 6: References (2 personal and 2 professional)

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Section 7: Verification and Consent

I verify that the above information is accurate to the best of my knowledge. Should any of my information change, I will notify the Licking County Health Department of the change. Should the Status of my license(s) change in any way, I will notify the Licking County Health Department immediately as to the change of any pending actions against me.

I give Licking County Health Department permission to inquire into my educational background, licenses, references, police records, and employment and/or volunteer history. I also give permission to the holder of any such information to release it to the Licking County Health Department.

I hold the Licking County Health Department harmless of any liability, criminal or civil, that may arise as a result of the release of any of this information about me. I also hold harmless any individual or organization that provides information to the above-named agency. I understand that the Licking County Health Department will use this information only as a part of the verification process associated with my volunteer application.

_____ Name (please print)	_____ Social Security
_____ Signature	_____ Date

**Return to: David Polakowski, MRC Volunteer Coordinator
Licking County Health Department
675 Price Rd.
Newark, Ohio 43055**