LICKING COUNTY
HEALTH DEPARTMENT

LICKING COUNTY MEDICAL RESERVE CORPS

VOLUNTEER APPLICATION

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

Section 1: Personal Information

Name:

____

Address:

____

____

City: __________________________________

State: ______________ Zip: _______________

Home Phone: ___________________________

Mobile Phone: __________________________

E-mail address:

____

Emergency Contact Name:

____

Emergency Contact Phone: ________________

Current Occupation:

____

Employer:

____

Employer Address:

____

____

Work Phone: ___________________________

Section 2: Skills and Education

1st Degree: _____________________________

Institution:

____

Dates Attended: _________________________

2nd Degree: _____________________________

Institution:

____

Dates Attended: _________________________

3rd Degree: _____________________________

Institution:

____

Dates Attended: _________________________

1st License held:

____

Expiration Date: _________________________

License Number: _________________________

Pending Action? Y___ N ___ 2nd

License held:

____

Expiration Date: _________________________

License Number: _________________________

Pending Action? Y___ N ___

LICKING COUNTY HEALTH DEPARTMENT

Section 3: Relevant Experience

Position Organization Dates

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____

Section 4: Volunteering Preferences Circle your availability.

Sundays	Mondays	Tuesdays	Wednesdays	Thursdays	Fridays	Saturdays
Mornings	Mornings	Mornings	Mornings	Mornings	Mornings	Mornings
Afternoons	Afternoons	Afternoons	Afternoons	Afternoons	Afternoons	Afternoons
Nights	Nights	Nights	Nights	Nights	Nights	Nights

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? Y ____ N ____

Are you interested in obtaining training in addition to the required training, such as disaster response training or opportunities for continuing education credits? Y ____ N ____

Section 6: 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 or any pending actions against me.

I give the 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) Signature Date

Return this form to:

Julie Hill BSN, RN, Nursing Manager & Medical Reserve Corps Coordinator
Jhill@lickingcohealth.org
Phone: 740-349-1523
Fax: 740-349-6510