



Registration Form

Please print clearly

Today's date _____

Personal Contact Information

Last Name _____ First Name _____ Middle _____

Home Address _____ Apt. No. _____

City _____ State _____ Zip Code _____ County of Residence _____

Home Phone (____) _____ Work Phone (____) _____ ext. _____

Cell Phone (____) _____ Email Address _____

Work Contact Information

Occupation _____ Specialty _____

Board Certified? Yes No

Full time Part time Retired Student

Employer _____ Address _____

City _____ State _____ Zip Code _____

Do you have prescriptive authority? Yes No

Is Michigan Licensure/certification required to practice in your profession/specialty? Yes No

Michigan Licensure # _____ Certification # _____ Exp. Date _____

Please list credentials/certificates (current and/or inactive) that you have that may be relevant to possible volunteer activities _____

Have you ever had your medical license suspended? Yes No If yes, please explain _____

Have you ever had your medical license revoked? Yes No If yes, please explain _____

Background Information

Birth Date _____ Place of Birth _____ Gender Male Female

Martial Status _____ Spouse's Name _____

Driver's License Number _____ State Issued _____ Expiration Date _____

Have you ever been convicted of a felony? Yes No If yes, please explain _____

Have you ever been convicted of a misdemeanor? Yes No If yes, please explain _____

Will you consent to a criminal background check? Yes No

Will you consent to credential verification? Yes No

What is the highest level of education you ever have completed? _____

Do you have any personal health issues that may impact your ability to volunteer (e.g., allergies, medication issues, disabilities, special needs or being treated for a medical condition)? Yes No If yes, please list here or speak personally with the MRC Coordinator _____

Please list any potentially relevant work experiences: _____

Please list any potentially relevant volunteer experiences: _____

What are your expectations for the Washtenaw County Medical Reserve Corps: _____

Previous Training

Do you have any disaster/emergency response experience? Yes No If yes, describe _____

Do you have any public health response experience? Yes No If yes, describe_____

Do you have any disaster/crisis training or experience? Yes No If yes, describe_____

Please list any other training or special skills you bring to the Medical Reserve Corps: _____

Language other than English spoken:

_____ **Fluency:** Excellent Fair Poor **Read and write:** Yes No
_____ **Fluency:** Excellent Fair Poor **Read and write:** Yes No
_____ **Fluency:** Excellent Fair Poor **Read and write:** Yes No

Availability

Do you have a role in emergency/disaster preparedness/response with any other organizations? Yes No
If yes, will that role affect your availability in an emergency situation? Yes No If yes, please explain_____

Do you have children or family members that would need care in the event that you are activated for a disaster? Yes No Ages_____Any special needs?_____

Do you have animals that would need to be cared for in the event you are activated? (**List type and number**)
 Yes No ___Dog(s) ___Cat(s) ___Bird(s) ___Livestock—type:_____ Other_____

I am interested in participating in:

- Emergency situations only
- Emergency situations, pre-event trainings and exercises
- Emergency situations, pre-event trainings, exercises and non-emergency public health functions

Please indicate when you are available for future trainings and to volunteer for non-emergency MRC activities (please check all that apply):

- | | | | |
|------------------------------------|----------------------------------|------------------------------------|----------------------------------|
| <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 |

Consent

The Medical Reserve Corps recognizes its responsibility to volunteer staff to assure fair and equal treatment and will not discriminate on the basis of color, religion, age , sexual orientation 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 Medical Reserve Corps Volunteer I may not accept payment for my services and that I will incur the cost of transportation. I will also take part in 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 Medical Reserve Corps reserves the right to disqualify or reject any volunteer.

Signature_____Date_____

Media Permission*:

I give my permission to be interviewed and/or photographed for publicity purposes. I understand that this information may appear publicly in a newspaper or other advertising media.

Signature_____Date_____

*Please note that your photograph will only be used if you sign this release.

Washtenaw County Medical Reserve Corps

Emergency Contact Information

Date: _____

Member Name: _____

Emergency Contact Information

1) Name _____ Relationship _____ Phone Number (____) _____

Address _____ City _____ State _____ Zip Code _____

2) Name _____ Relationship _____ Phone Number (____) _____

Address _____ City _____ State _____ Zip Code _____

3) Name _____ Relationship _____ Phone Number (____) _____

Address _____ City _____ State _____ Zip Code _____

Signature: _____ Date: _____