Logan County Medical Reserve Corps

MRC Application Date:

Application Information

Full Name: _____
Last *First* *Middle*

Address: _____
Street Address *Apt. #*

_____
City *State* *Zip Code*

Home Phone: _____ Work Phone: _____

Email Address: _____

Driver's License #: _____

Sex: ☐ Male ☐ Female Birth date: _____ Age: _____

Are you a citizen of the United States? ☐ Yes ☐ No

Have you ever volunteered or worked in or for Logan County? ☐ Yes ☐ No

If so, when and where? _____

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, explain? _____

Education

Highest Level of Education: ☐ High School ☐ College ☐ Graduate School

High School: _____ Address: _____

Graduation Date: _____ Degree: _____

College: _____ Address: _____

Graduation Date: _____ Degree: _____

Graduate School: _____ Address: _____

Graduation Date: _____ Degree: _____

Other: _____ Address: _____

Graduation Date: _____ Degree: _____

Professional License/Certification

Are you certified or licensed in any health field? ☐ Yes ☐ No

If yes, please mark all applicable degrees:

☐ M.D./D.O. ☐ D.V.M./V.M.D. ☐ R.N.
☐ L.P.N. ☐ EMT/Paramedic ☐ P.A./N.P.
☐ Pharmacist ☐ Psychiatrist ☐ Counselor
☐ D.D.S./D.M.D.
☐ Other, please state: _____

Professional License #: _____
Ever suspended or revoked? ☐ Yes ☐ No

Actively Practicing? ☐ Yes ☐ No If yes, indicate: ☐ Full-time ☐ Part-time
Current Employer: _____
Retired? ☐ Yes ☐ No

Area(s) of expertise/interest or volunteer preferences:

☐ Public Health Clinics	☐ Shelter
☐ Support	☐ Natural Disasters
☐ Disease Outbreak	☐ Injections
☐ Medical Dispensing	☐ Interviewing
☐ Administer Vaccines	☐ Phone Tree
☐ Chart Review	☐ Medical History
☐ Operations	☐ Special Needs
☐ _____	☐ _____

Trainings

Please mark the trainings you have completed. Indicate the certification date and certifying agency.

	Date	Agency
☐ CPR		
☐ AED		
☐ First Aid		
☐ Disaster Training		
☐ Blood Borne Pathogens		
☐ Incident Management		
☐ Basic Epidemiology		
☐ Foreign Language		

Language(s) spoken: _____
Level of fluency: ☐ Excellent ☐ Fair ☐ Poor
Read and Write: ☐ Yes ☐ No

Vaccine History

Please indicate if you have been vaccinated against any of the following pathogens. In addition, provide the date of the vaccination.

		Date
Anthrax	☐ Yes ☐ No	
Influenza	☐ Yes ☐ No	
Hepatitis A	☐ Yes ☐ No	
Hepatitis B	☐ Yes ☐ No	
Meningitis	☐ Yes ☐ No	
Smallpox	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
Tularemia	☐ Yes ☐ No	
Other		

Employment

Company: _____ Phone: _____
Address: _____
Supervisor: _____ Job Title: _____
Responsibilities: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No

Company: _____ Phone: _____
Address: _____
Supervisor: _____ Job Title: _____
Responsibilities: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No

Company: _____ Phone: _____
Address: _____
Supervisor: _____ Job Title: _____
Responsibilities: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No

References

Please list three professional references.

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Military Service

Are you or have you been a member of the military? ☐ Yes ☐ No

Branch: _____ From: _____ To: _____
Rank at Discharge: _____ Type of Discharge: _____
If other than honorable, explain: _____

Availability/Response Time

Availability: ☐ During an emergency only
☐ As-needed throughout the year
☐ During an emergency in another capacity than the skill(s) specified
☐ In any capacity at any time needed

Response Time: ☐ Able to response immediately
☐ Within 24 hours
☐ Within 48 hours

Part of another emergency/disaster alert system? ☐ Yes ☐ No
Please List: _____

What are your family requirements and/or other requirements if the LC MRC is activated? _____

Number of family members: _____ Number of children: _____
Emergency Contact: _____
Relationship: _____ Phone Number: (217) _____

Disclaimer/Signature

Authorization

I hereby give the Logan County Medical Reserve Corps (LC MRC) permission to inquire into my educational background, references, driving record, employment history, volunteer history, health history, and police record. Furthermore, I give permission to the holder of any such records to release the same to the LC MRC. I hereby hold the LC MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of the information about me. Also, I hold harmless any individual, agency, business, or corporation that provides documents of the LC MRC. I understand that the LC MRC will use this information as part of its verification of my volunteer application. Moreover, I understand that as a LC MRC volunteer, I am not paid for my services.

Volunteer Consent for Release of Information

I hereby give the LC MRC permission to share information with local, state, and federal emergency agencies and other Health and Human Services agencies as needed.

_____

Signature *Date*

Be prepared. Be committed. Be a Logan County Medical Reserve Corps volunteer.

Please submit your application and supporting documentation (resume, certification/license credentials, etc.) either by mail:

Mail Logan County Department of Public Health
Emergency Response Coordinator
109 Third Street
Lincoln, IL 62656-0508

or:

Email stracy@lcdph.org