



Scott County Medical Reserve Corps.



Volunteer Application

Personal Information		
Name:		
Street Address:		
City:	State:	Zip Code:
Primary Phone:		
Secondary Phone:		
Email:	Employer:	

Emergency Contact		
Name:	Relationship:	
Street Address:		
City:	State:	Zip Code:
Primary Phone:		

Skills and Training		
MEDICAL LICENSE OR CERTIFICATION	OTHER	ADDITIONAL TRAINING/EXPIERENCE
<input type="checkbox"/> Doctor Specialty	<input type="checkbox"/> Clergy	<input type="checkbox"/> List any Other ICS Training:
<input type="checkbox"/> Physician's Assistant Specialty	<input type="checkbox"/> Forklift, Flagger, CDL's <input type="checkbox"/> Informational Technologist (IT)	
<input type="checkbox"/> Dentist	<input type="checkbox"/> Psychological First Aid	
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Medical Office Management	
<input type="checkbox"/> Nursing NP CNM RN CNRA LPN CAN Type:	<input type="checkbox"/> Media/Public Relations/PIO	<input type="checkbox"/> Data Entry
<input type="checkbox"/> Veterinary Specialty	<input type="checkbox"/> Hazmat	<input type="checkbox"/> Office Skills
<input type="checkbox"/> Paramedic/EMT/Etc. Type:	<input type="checkbox"/> Weather Spotter	<input type="checkbox"/> HAM Radio Operator
<input type="checkbox"/> Therapist: Type:	<input type="checkbox"/> CPR/AED or BCLS or ACLS Expires:	Call Sign : Class: <input type="checkbox"/> Sign Language
<input type="checkbox"/> Mental Health Professional Type:	<input type="checkbox"/> NIMS 100	<input type="checkbox"/> Other Languages
<input type="checkbox"/> Other (Technician, Assistant, Etc.) Type:	<input type="checkbox"/> NIMS 200	Which:
	<input type="checkbox"/> NIMS 300	Current License Information
	<input type="checkbox"/> NIMS 400	Type:
	<input type="checkbox"/> NIMS 700	State Issued:
	<input type="checkbox"/> NIMS 800	Number:
		Expiration Date:

**UNIFORM SHIRT
SIZE:** _____

SEE REVERSE SIDE

Additional Information	
Where are you interested in volunteering? <input type="radio"/> Local <input type="radio"/> Statewide <input type="radio"/> Nationally	
How frequently would you like to volunteer? <input type="radio"/> Regularly <input type="radio"/> Occasionally <input type="radio"/> Emergency Only	
Best time to contact: <input type="radio"/> Daytime <input type="radio"/> Evenings <input type="radio"/> Weekdays <input type="radio"/> Weekends	
Best Form of Contact: <input type="radio"/> Phone <input type="radio"/> Email <input type="radio"/> Text	
Are you interested in participating in non-disaster community events? <input type="radio"/> Yes <input type="radio"/> No	
Do you have any special needs or restrictions? If so, please explain:	
Please list any other volunteer organizations you participate in:	
Do you have any disaster experience? <input type="radio"/> Yes <input type="radio"/> No	
List any related skills or training that you are authorized to teach:	

For Office Use Only		
<input type="checkbox"/> Added to Contact List	<input type="checkbox"/> Tier One Training Completed	<input type="checkbox"/> Photo taken for ID
<input type="checkbox"/> License/Certification Approved	<input type="checkbox"/> Tier Two Training Completed	<input type="checkbox"/> Photo ID issue date: _____
<input type="checkbox"/> Required training documented	<input type="checkbox"/> Tier Three Training Completed	
<u>Course Title</u> - -	MRC Items Issued:	
<input type="checkbox"/> ICS-100	_____	
<input type="checkbox"/> NIMS-700	_____	
<input type="checkbox"/> FEMA IS-22	_____	
<input type="checkbox"/> TRANE -MRC Orientation	_____	
<input type="checkbox"/> TRANE-MRC Family Disaster Planning	_____	
<input type="checkbox"/> Terrorism Preparedness	_____	

SIGNATURE of Volunteer: _____

Date Signed: _____

By signing this form, I agree to be a Volunteer of the Scott County Health Department, and authorize a background check to be completed by local law enforcement if warranted.

PLEASE RETURN APPLICATION TO:
 SCOTT COUNTY MRC
 1471 North Gardner Street
 Scottsburg, IN 47170
 812/752-8460 (P)
 812/752-6023 (F)
 ATTN: Patti Hall, MRC Unit Leader

