



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 Birthdate: _____ 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:

- | | |
|--|--|
| <input type="checkbox"/> Public Health Clinics | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Support | <input type="checkbox"/> Natural Disasters |
| <input type="checkbox"/> Disease Outbreak | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Medical Dispensing | <input type="checkbox"/> Interviewing |
| <input type="checkbox"/> Administer Vaccines | <input type="checkbox"/> Phone Tree |
| <input type="checkbox"/> Chart Review | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Operations | <input type="checkbox"/> Special Needs |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Trainings

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

	Date	Agency
<input type="checkbox"/> CPR	_____	_____
<input type="checkbox"/> AED	_____	_____
<input type="checkbox"/> First Aid	_____	_____
<input type="checkbox"/> Disaster Training	_____	_____
<input type="checkbox"/> Blood Borne Pathogens	_____	_____
<input type="checkbox"/> Incident Management	_____	_____
<input type="checkbox"/> Basic Epidemiology	_____	_____
<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Influenza <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Smallpox <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tetanus <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tularemia <input type="checkbox"/> Yes <input type="checkbox"/> 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 or email to:

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

Email mlamb@logancountyhealth.org