

Section III. Licenses or Certification

Driver's License #		State(s)	Expiration
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Specialty	Number	State(s)	Expiration
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Specialty	Number	State(s)	Expiration
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Section IV. Education

Last School Attended _____ Location (City, State) _____

List ALL Majors and Degrees Earned _____ Year(s) Awarded _____

Section V. Additional Certifications

	Most Recent Date	Certifying Agency
1. CPR: Adult ___ Child ___ Infant ___ AED ___	_____	_____
2. First Aid	_____	_____
3. Disaster Training	_____	_____
4. CERT(Community Em. Response Team)	_____	_____
5. Blood Borne Pathogens	_____	_____
6. Other _____	_____	_____

Section VI. References

List two individuals (not related to you) who are familiar with your qualifications and/or experience. These references may be checked for verification of information provided in this application.

1. _____
Last Name _____ First _____ Occupation _____

Business or Home Address _____

Phone _____

2. _____
Last Name _____ First _____ Occupation _____

Business or Home Address _____

Phone _____

Section VII. Other Skills

Office or Medical Skills

Do you have experience entering data into a computer database?

- I do this routinely (at least once a month)
- I do not do this routinely, but have prior experience and would be able to if need.
- I have no experience with this.

Do you have access to the Internet at home? **YES** **NO**

Are you able to receive email at home? **YES** **NO**

Do you or have you supervised staff or volunteers? **YES** **NO**

Have you been trained to draw blood?

- I do this routinely
- I do not do this routinely, but have prior experience and would be able to if necessary.
- I have no experience with this.

Indicate which groups or groups you have experience with in drawing blood.

Adults Children Infants

Have you been trained to give injections?

- I do this routinely
- I do not do this routinely, but have prior experience and would be able to if necessary.
- I have no experience with this.

Please specify if you have experience giving the following types of injections:

Intramuscular Subcutaneous Intradermal

Please indicate which group or groups you have experience with in giving injections.

Adults Children Infants

Have you ever administered small pox vaccine? **YES** **NO**

Section VIII. Related Experience and Training

- | | |
|---|----------------------|
| 1. Are you familiar with Incident Command System of Emergency Management?
If yes, specify level of training Not at all _____ Somewhat _____ Fully Trained _____ | YES NO |
| 2. Are you familiar with basic principles of epidemiology?
If yes, specify level of familiarity Not at all _____ Somewhat _____ Fully Trained _____ | YES NO |
| 3. Have had any training regarding terrorism preparedness or emergency response to terrorism?
If yes, please specify type of training | YES NO |

Please describe any additional specialized skills or training applicable to the MRC: (E.g. Hurricane Katrina Volunteer, Radio Operator, etc.)

Section IX. Languages (Non - English) Please indicate whether **basic (B)**, **intermediate (I)**, or **advanced (A)**.

Language	Read	Write	Speak
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Language	Read	Write	Speak
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Section X. Vaccine History

Have you been vaccinated against any of the following pathogens?

If yes, list the year of your last vaccination.

			Year
1. Anthrax	YES	NO	_____
2. Influenza	YES	NO	_____
3. Hepatitis A	YES	NO	_____
4. Hepatitis B	YES	NO	_____
5. Meningitis	YES	NO	_____
6. Smallpox	YES	NO	_____
7. Tetanus	YES	NO	_____
8. Tularemia	YES	NO	_____
9. Other _____			_____

Section XI. Additional

Individual Considerations That Affect Your Ability to Volunteer (Allergies, Special Needs, Medical Problems, Availability):

Allergies: _____

Section XII. Volunteering Areas

MRC responsibilities may be subdivided into the following areas, please rate your interest from 1 to 4, 1 as the most interested

1. Emergency Response Team - Medical and/or Support	1	2	3	4
2. Public Health Information, Education/ Community Outreach and Networking	1	2	3	4
3. Volunteer Training and Management/Continuing Education	1	2	3	4
4. Administrative Support and Credentialing	1	2	3	4
5. Mass Sheltering (Human and Animal) resource development	1	2	3	4

I authorize the City of Evanston to conduct inquiry and verification of all statements contained in this application for membership to the Medical Reserve Corps. I authorize the release of any personal and criminal history for Medical Reserve Corps Volunteer membership. I understand that any misrepresentation or omission of facts, regardless of date of discovery, may be considered grounds for termination or the withdrawal of an offer of membership. I understand that submission of this application or membership in the Medical Reserve Corps does not imply status to any individual or organization as an agent or employee of the City of Evanston. I understand that the Evanston Medical Reserve Corps is under the Evanston Citizens Corps Council, which is a branch of the Emergency Management Agency. I also agree to abide by all rules and policies enacted by the Medical Reserve Corps.

I certify that the information given herein is true and correct to the best of my knowledge and belief.

Signature of applicant _____ Date _____

FOR OFFICE USE ONLY

Physicians	<input type="checkbox"/>	Physician Assistants	<input type="checkbox"/>
Nurse Practitioners	<input type="checkbox"/>	Nurses	<input type="checkbox"/>
Pharmacists	<input type="checkbox"/>	Dentists	<input type="checkbox"/>
Veterinarians	<input type="checkbox"/>	Mental Health Professionals	<input type="checkbox"/>
EMS Professionals	<input type="checkbox"/>	Respiratory Therapists	<input type="checkbox"/>
Other Public Health/Medical	<input type="checkbox"/>	Non-Public Health/Medical	<input type="checkbox"/>
