



Volunteer Application

Please return to:

GH Public Health and Social Services
 ATTN: Medical Reserve Corps
 2109 Sumner Ave
 Aberdeen, WA 98520

(360) 532-8631 FAX (360) 533-1983

Contact Information								
Name: Last:		First:		MI:		Suffix:		Nickname:
Title: Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Other			How did you hear about the Medical Reserve Corps: Radio <input type="checkbox"/> Mailing <input type="checkbox"/> Website <input type="checkbox"/> Presentation <input type="checkbox"/> Other					
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Are you currently an employee of Grays Harbor County <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you a US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address:				Apt:				
Address 2:			City:		State:		Zip:	
Phone Home: () -			Work: () -			ext.		
Cell: () -			Text: () -			Pager: () -		
E-Mail 1:				E-Mail 2:				
What interests you in the Medical Reserve Corps?								
Preferred Contact Method(s)		<input type="checkbox"/> Work		<input type="checkbox"/> Home		<input type="checkbox"/> Cell		<input type="checkbox"/> Text
		<input type="checkbox"/> Pager		<input type="checkbox"/> E-Mail 1		<input type="checkbox"/> E-Mail 2		
Best time to contact:		<input type="checkbox"/> Days		<input type="checkbox"/> Evening				
Do you possess a valid WA state driver's license?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Exp. Date:		Class:		State: License #:
Employment Information								
Place of Employment:						Position:		
Work Address:			City:		State:		Zip:	
Primary Responsibilities:								
Emergency Contact – Will be notified in case of an emergency								
Name Last:			First Name:			Relationship:		
Address:				City:		State:		Zip:
Phone Number: () -				Alternate phone Number: () -				
Additional Information								
Language:		Fluent? <input type="checkbox"/>		Speak? <input type="checkbox"/>		Read? <input type="checkbox"/>		Write? <input type="checkbox"/>
Language:		Fluent? <input type="checkbox"/>		Speak? <input type="checkbox"/>		Read? <input type="checkbox"/>		Write? <input type="checkbox"/>
Preferences (Please Note: Answers do <u>not</u> affect the ability to volunteer)								
Are you interested in volunteering outside of Grays Harbor County?						<input type="checkbox"/> Yes		<input type="checkbox"/> No
Are you interested in volunteering outside of Washington state?						<input type="checkbox"/> Yes		<input type="checkbox"/> No
Are you committed to any other organization in the event of a public health emergency, by virtue of employment or volunteerism?						<input type="checkbox"/> Yes		<input type="checkbox"/> No
Are you willing to have your name added to the Washington State registry of emergency healthcare volunteers?						<input type="checkbox"/> Yes		<input type="checkbox"/> No
How much notice would you need to respond to an emergency activation?				<input type="checkbox"/> 4 hours		<input type="checkbox"/> 24 hours		<input type="checkbox"/> 3 days
				<input type="checkbox"/> 1 week		<input type="checkbox"/> Not Sure		
In the event of an emergency activation which order should we use to contact you? (1, 2, 3 etc...)		Work	Home	Cell	Text	Pager	E-Mail 1	E-Mail 2
Not Sure								
Experience: Do you have any of the following skills?								
<input type="checkbox"/> CPR/First Aid		<input type="checkbox"/> Epidemiologist		<input type="checkbox"/> Pastoral Care Professional		<input type="checkbox"/> Interviewing		
<input type="checkbox"/> Clerical Work		<input type="checkbox"/> Elderly/Disabled assistance		<input type="checkbox"/> Public Speaking		<input type="checkbox"/> Inventory Supplies		
<input type="checkbox"/> Computer Skills		<input type="checkbox"/> Retired Healthcare Professional		<input type="checkbox"/> Management/Supervision		<input type="checkbox"/> Education/Teaching		
<input type="checkbox"/> Counseling Skills		<input type="checkbox"/> Customer Service		<input type="checkbox"/> Phones/Switchboard		<input type="checkbox"/> Security/Law Enforcement		
<input type="checkbox"/> Crowd Management		<input type="checkbox"/> Data Entry		<input type="checkbox"/> Office Management		<input type="checkbox"/> Other:		

Training/Continuing Education		
Have you completed any training or continuing education in the following areas?		
<input type="checkbox"/> Advanced Cardiac Life Support (ACLS)	<input type="checkbox"/> Citizen Emergency Response Team	<input type="checkbox"/> Isolation and Quarantine
<input type="checkbox"/> Advanced Trauma Life Support (ATLS)	<input type="checkbox"/> CPR/AED	<input type="checkbox"/> Mental Health Training for Disasters
<input type="checkbox"/> Basic Cardiac Life Support (BLS)	<input type="checkbox"/> Emergency Preparedness	<input type="checkbox"/> Triage
<input type="checkbox"/> Basic Disaster Life Support (BDLS)	<input type="checkbox"/> Exercise Design and Evaluation	<input type="checkbox"/> Vaccination Administration
<input type="checkbox"/> Bloodborne Pathogens	<input type="checkbox"/> First Aid	<input type="checkbox"/> Other:
<input type="checkbox"/> CBRNE Training	<input type="checkbox"/> Incident Command Training (ICS)	
Other Experience		
Please feel free to add any other experience or training including volunteer, work or life experience.		
References		
Please list three professional or personal references from people other than family members.		
Name:	Phone: () - ext.	How you know this person:
Name:	Phone: () - ext.	How you know this person:
Name:	Phone: () - ext.	How you know this person:
Education		
School:	City/State:	Degree(s):
School:	City/State:	Degree(s):
School:	City/State:	Degree(s):
For Health Professionals Only		
Professional Licensure, Certification, Specialties, Experience		
Name on License/Certification:	State:	
License/Certification Number:	Exp. Date:	
Specialty within the above professional licensure/certification that you possess:		
Sub specialty with the above professional licensure/certification that you possess:		
Name on License/Certification:	State:	
License/Certification Number:	Exp. Date:	
Specialty within the above professional licensure/certification that you possess:		
Sub specialty with the above professional licensure/certification that you possess:		
Other:		
Release of Information		
<p><i>I verify that the information provided in the Grays Harbor Medical Reserve Corps application is accurate to the best of my knowledge. I give permission for Grays Harbor County to inquire into my educational background, references, licenses, driving records, police reports, employment or volunteer history.</i></p> <p><i>I also give permission to the holder of any such information to release it to Grays Harbor County.</i></p> <p><i>I hold Grays Harbor County harmless of any liability, criminal or civil, that may arise as a result of the release of this information. I also hold harmless any individual or organization that provides information to the above-named agency. I understand that Grays Harbor County will use this information only as part of its verification of my volunteer application.</i></p>		

Applicant Signature: _____

Date: _____