



133 South 500 East, Vernal, UT 84078
 (435) 247-1170 Fax (435) 781-0537

FULL NAME:	DATE:
JOB TITLE:	EMAIL ADDRESS:
STREET ADDRESS:	CITY: STATE: ZIP:
HOME PHONE:	MOBILE PHONE:
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:

WORK: FULL TIME ___ PART TIME ___ RETIRED ___ OTHER ___

PROFESSIONAL INFORMATION(MARK ALL THAT APPLY)

___ PHYSICIAN: AREA OF SPECIALTY: _____

BOARD CERTIFIED? YES NO

___ NURSE: RN LPN NURSE PRACTITIONER SPECIALTY: _____

___ EMT ___ PARAMEDIC ___ PHARMACIST ___ SOCIAL WORKER

___ MENTAL HEALTH PRACTITIONER: PSYCHOLOGIST OTHER _____

___ PHYSICIAN ASSISTANT ___ NURSE ASSISTANT ___ MEDICAL ASSISTANT

___ DENTIST ___ VETERINARIAN ___ ENVIRONMENTAL HEALTH SPECIALIST

___ HEALTH EDUCATOR ___ HEALTH TECH.:TYPE _____

___ PUBLIC RELATIONS ___ MEDIA/COMMUNICATIONS CLERGY:DENOMINATION _____

___ FAITH BASED RECRUIT(MARK HERE IF YOU RECEIVED THIS FROM YOUR CHURCH)

___ OTHER _____

LICENSE & CERTIFICATIONS

License Number & Discipline: _____

Have you ever had your professional license suspended or revoked? Yes No If yes, please explain: _____

Specialty Information

Specialty/Subspecialty: _____

Board Certifications or other Certifications: _____

Specialty skills related to emergency situations: _____

OTHER SKILLS

Are you CPR certified? Yes No

Are you AED certified? Yes No

Are you first aid certified? Yes No

Language fluency, besides English: _____

Are you willing to volunteer in a disaster, even if your medical expertise may not be needed?
 (ie: flood, assist with sandbagging, helping people to safety, etc.)

Yes No

Response time and estimated time available (circle which applies)

Respond Time	Estimated Time Available
Able to reSpond immediately	1-3 Days
Able to respond in 24 hours	3 Days to 1 week
Able to respond in 48 hours	1-2 Weeks

Are you part of any other emergency / disaster alert system? Yes No

Please List: _____

Do you have children family members that would need care in the event that you are activated? Yes No

I do hereby give *TriCounty Medical Reserve Corp* permission to inquire into my educational background, reference, driving record, employment, volunteer history, and police record. I further give permission to the holder of any such records to release the same to *TriCounty Medical Reserve Corp*. I hereby hold *TriCounty Medical Reserve Corp* harmless and individual, agency, business or corporation that provides documentation to *TriCounty MRC*. I understand that *TriCounty MRC* will use this information as part of its verification of my volunteer application. I further understand that as a *Medical Reserve Corps* volunteer I am not paid for my services.

Volunteer Consent for Release Information

I do hereby give *TriCounty MRC* permission to release personal information with local, state, and federal emergency management agencies and other Health and Human Services agencies as needed.

Signature

Date

Data for Background Check:

Drivers License Number with Expiration Date

Date of Birth:

Social Security Number:

