



# Eastern Nebraska Medical Reserve Corps VOLUNTEER APPLICATION

## PERSONAL CONTACT INFORMATION ( KEPT CONFIDENTIAL)

**NAME:** Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**ADDRESS:** Street \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PHONE:** Home \_\_\_\_\_ Mobile \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

The following information is required for a background check. Your information will be kept confidential.

**Date of Birth** \_\_\_\_\_ **Place of Birth** \_\_\_\_\_

**Drivers License #** \_\_\_\_\_

**Gender**

**Ethnic Group:**

Have you ever been convicted of a felony? A misdemeanor? (not traffic violations)  
If yes, please explain:

## EMERGENCY CONTACT INFORMATION:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Mobile \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## SKILLS

### FOREIGN LANGUAGE:

What languages do you **speak** or understand other than English?

\_\_\_\_\_ Speak \_\_\_\_\_ Write \_\_\_\_\_ Read \_\_\_\_\_

\_\_\_\_\_ Speak \_\_\_\_\_ Write \_\_\_\_\_ Read \_\_\_\_\_

## LICENSING/CERTIFICATIONS

License #      State      Expiration

\_\_\_\_\_  
 \_\_\_\_\_

Are you board certified? Yes\_\_\_ No\_\_\_

Do you have prescriptive authority? Yes\_\_\_ No\_\_\_

## CERTIFICATIONS AND TRAINING

Certifications	Most Recent Date	Certifying Agency
<input type="checkbox"/> CPR	_____	_____
<input type="checkbox"/> First Aid	_____	_____
<input type="checkbox"/> Disaster Training	_____	_____
<input type="checkbox"/> Cert	_____	_____
<input type="checkbox"/> Bloodborne Pathogen	_____	_____
<input type="checkbox"/> Incident Command System	_____	_____
<input type="checkbox"/> Epidemiology	_____	_____
<input type="checkbox"/> Bioterrorism	_____	_____
<input type="checkbox"/> Other	_____	_____

## WORK CONTACT INFORMATION

OCCUPATION: \_\_\_\_\_ Full time\_\_\_ Part time \_\_\_ Retired \_\_\_\_\_

### PRESENT EMPLOYER:

Company \_\_\_\_\_ Position \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Professional License

In the event of **YOUR OWN MEDICAL EMERGENCY** we need you to complete the following Medical Screen.

Medical Condition	Yes	No	Explain	Medication(s)
-------------------	-----	----	---------	---------------

Heart or vessel \_\_\_\_\_

Lung or breathing problems \_\_\_\_\_

Stomach or intestinal \_\_\_\_\_

Muscle or Orthopedic \_\_\_\_\_

Brain e.g. Seizures \_\_\_\_\_

Diabetes: Oral or Insulin \_\_\_\_\_

Allergies \_\_\_\_\_

Physical limitations that may interfere in your ability to assist? \_\_\_\_\_

I hereby certify that all the information shown above is accurate and correct and I hereby make application for member in the Eastern Nebraska/Western Iowa Medical Reserve Corps. I understand that I am applying for a volunteer position and that this is not an application for, or contract of, employment.

I understand that every attempt will be made to reduce risks to volunteers, however some risks may be present during a public health emergency and I agree to assume my own risk as a volunteer.

I do hereby give the Eastern Nebraska/Western Iowa Medical Reserve Corps permission to inquire into my educational background, references, driving record, police records, employment and my volunteer history. I further give permission to the holder of any such records to release same to the Eastern Nebraska/Western Iowa Medical Reserve Corps. I understand that the Eastern Nebraska/Western Iowa Medical Reserve Corps will only use this information as part of its verification of my volunteer application and periodically for evaluation purposes. I do hereby hold the Eastern Nebraska/Western Iowa Medical Reserve Corps harmless from any liability, whether civil or criminal, that may arise as a result of their release of this information about me. I further hold harmless any individual, agency, business or corporation that provides information or documents to the Eastern Nebraska/Western Iowa Medical Reserve Corps.

A Photocopy of this release form will be valid as an original thereof even though the said photocopy does not contain an original writing of my signature.

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**RETURN COMPLETED APPLICATION TO:**

**Eastern Nebraska Medical Reserve Corps  
Megan Wade – MRC Coordinator  
1414 S. Washington Street  
Papillion, NE 68046**

**Phone: 402-957-4380**

**E-mail: MRCCoord@gmail.com**