

Sedgwick County Medical Reserve Corp Volunteer Application



Please print clearly

Personal Contact Information

Last Name _____ First Name _____ MI _____
 Maiden name/other names used: _____ KS Drivers License # _____
 Home Address: _____ Apt # _____
 County _____ City _____ State _____ Zip Code _____
 Home Phone # () _____ Cell Phone () _____ Other () _____
 E-mail _____ Pager # _____ Other _____
 In case an emergency happens to me, please contact:
 Name: _____ Relationship: _____
 Daytime phone number: _____ Evening phone number: _____

Although the focus of our unit is on local and surrounding county's emergencies, would you like us to call you in case of a statewide or national emergency (such as Hurricane Katrina relief efforts in 2005)? YES NO

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

Date of Birth: _____ Place of Birth: _____
 Gender: M F Social Security #: _____ - _____ - _____
 Race/Ethnic Group (Circle one):
 Black White Hispanic American Indian/Alaskan Indian Asian/Pacific Islander
 Have you ever been convicted of a felony Yes No A misdemeanor? (Other than traffic violations) Yes No
 If yes, please explain and state in which conviction occurred: _____

Employer Contact Information

Occupation _____ (please circle) Full Time Part Time Retired Student
 Employer _____ Address _____
 General Phone Number () _____ Your extension _____
 In the event, volunteers are activated to respond to an emergency: Please list additional person(s) who may be used to contact you if we are unable to reach you using the information provided above.
 Contact Name _____ Phone Number () _____ Relationship _____

Education

Education (circle highest level completed) High School College Graduate School Other _____
School Name: _____ Location: _____ Year Graduated: _____
Type of Degree: _____ Major/Specialation: _____

License (Professionals with a current license or certification in any health or mental health field)

- | <i>Circle all applicable</i> | <i>State Issued</i> | <i>License Number</i> | <i>Expiration Date</i> |
|--|----------------------|--|------------------------|
| 1. M.D./D.O. | _____ | _____ | _____ |
| 2. D.V.M./V.M.D. | _____ | _____ | _____ |
| 3. D.D.S./D.M.D. | _____ | _____ | _____ |
| 4. D.C. | _____ | _____ | _____ |
| 5. R.N. | _____ | _____ | _____ |
| 6. L.P.N. | _____ | _____ | _____ |
| 7. EMT / Paramedic | _____ | _____ | _____ |
| 8. P.A./N.P. | _____ | _____ | _____ |
| 9. Pharmacist | _____ | _____ | _____ |
| 10. Psychiatrist/Phychologist | _____ | _____ | _____ |
| 11. Other | _____ | _____ | _____ |
| 12. Social Work LSBCW LMSW LBSW | _____ | _____ | _____ |
| 13. Are you a Foreign Medical Doctor? | Yes No | If yes, what is your current U.S. medical certification? _____ | |
| 14. Other health related degrees or licenses | _____ | _____ | _____ |
| 15. Do you have prescriptive authority? | Yes No | _____ | _____ |

*****Please provide a copy of your current professional license and photo ID*****

Certifications and Trainings (complete those that apply)

<i>Certifications</i>	<i>Most Recent Date</i>	<i>Certifying Agency</i>
CPR	_____	_____
First Aid	_____	_____
Disaster Training	_____	_____
CERT	_____	_____
Bloodborne Pathogens & Standard Precautions	_____	_____
Military Medical Training	_____	_____
NIMS or Incident Command Training	_____	_____

Other certifications (medical, mental health, or non-health field)

Training

(Circle any that you have attended)

- | | |
|-------------------------|---|
| Incident Command System | Bioterrorism |
| Epidemiology | Terrorism & emergency response to terrorism |
| Other _____ | _____ |

Language

What languages do you speak other than English?

Language	Level of fluency	Read and write
_____	Excellent / Fair / Poor	Yes / No
_____	Excellent / Fair / Poor	Yes / No

Please list any other special skills you bring to the Medical Reserve Corps.

Areas of Interest (please circle your area of interest-you may chose more than one)

During an Emergency

Various areas require licensure however, many areas do not. Please circle areas that are interesting to you.

Form Completion and Collection	Assist with Vaccinations	Public Information	Educate Patients
Language Interpreter/Translator	Assist with Clinic Flow	Computer Support	Clinic Manager
Pharmaceutical Distributions	Supply/Stock Manager	As Needed Duties	Greet Patients
Mental Health Consultation	Medical Screenings	Register Patients	Data Entry

Non- Emergency Opportunities

Working directly with patients/clients

Assist with Flu Clinics	Provide Patient Education	Language Interpreter/Translator
Assist with Dental Clinics	Assist Patients with Forms	Assist with Children’s Health

Providing indirect support

Computer Support	Provide education/presentations	Clerical Assistance	Medical Records Assistance
------------------	---------------------------------	---------------------	----------------------------

Other

Please list at least three personal reference names (not family), phone number, and how long you have known them.

	Name	Phone Number	How Long Known
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please tell us why you want to be a volunteer.

Are you part of an emergency/disaster plan with any other group? (Red Cross, hospital, employer, etc?) Yes No

If yes, please list name of organization _____

If licensed, do you carry malpractice insurance? Yes No

Are you able to stand for extended periods? Yes No

Are you able to be away from family for 12 to 24 hours at a time, if activated in an emergency response? Yes No

Can you lift at least 20 to 25 pounds? Yes No

How did you learn about Medical Reserve Corps? _____

I hereby certify that all the information shown above is accurate and correct and I hereby make application for membership in the Sedgwick County 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.

Signature of applicant

Date

Please return application form to - Sedgwick County Medical Reserve Corps
1530 S. Oliver, Suite 130
Wichita, KS 67214
(316) 660-7344

Please include a copy of your photo ID (Drivers License), and any certifications or licenses you currently hold.