



Medical Reserve Corps Volunteer Application for Medical Professionals

Personal Information

Last Name: _____ First Name: _____ Initial: _____
 Address: _____ Apt/Sp: _____
 City: _____ State: _____ Zip: _____
 Phone (Home): _____ Phone (Work): _____
 Phone (Cell): _____ E-mail: _____
 Pager: _____ Gender: Male Female (Please circle)
 Date of Birth: _____
 (month/date/year)
 Drivers License Number: _____ State: _____ Restrictions: _____
 Automobile Liability Insurance Carrier: _____
 Emergency Contact: _____ Phone Number: _____
 Languages you speak: _____ Languages you write? _____
 Medical Conditions the MRC should be aware of, including allergies: _____

Employment Information (If you are retired, please complete this section with information relating to your most recent employment.)

Employer Name: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone: (_____) _____ Ext. _____ Fax: (_____) _____
 Supervisor: _____ Work e-mail: _____
 Dates of employment: From: _____ To: _____

MEDICAL RESERVE CORPS
P.O. BOX 3902, LAS VEGAS, NEVADA 89127
PHONE: (702) 759-0877 FAX (702) 383-6148
martel@cchd.org



I wish to offer my professional services to the Medical Reserve Corps as:

Professional Licensure, Certification, Specialties & Experience

(Please **attach a copy** of your license or certification. Also, **if you are not currently licensed**, please provide information related to your most recent licensure or certification.)

Name on License or Certification: _____

Licensed/Certified As: _____ License/Certification #: _____

Licensing Agency and State: _____ Expiration Date: _____

List any specialties within your professional licensure(s):

Next section to be completed by the MRC Program Coordinator

Date License/Certification Verified: _____

By Whom: _____

Date Issued: _____ Expires: _____

Actions: _____

Professional Experience/Specialized Training

(Please use the space below or you may attach a resume or CV.)

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References

Please provide two references of individuals familiar with your qualifications and/or experience.

NAME	ADDRESS	TELEPHONE
1.		()
2.		()

Medical Reserve Corps Volunteer Agreement

I, _____, offer to serve as a volunteer in the Medical Reserve Corps, within the Southern Nevada Health District, for response with a Medical Reserve Corps volunteer unit during local emergencies. In addition, I give permission to the Medical Reserve Corps to inquire into the status of my professional license or certification, references, employment and/or volunteer history.

My services will be those of a _____.

In making this offer of my professional services, I agree and/or understand that I will:

1. Perform my volunteer services and activities under the direction and guidance of the Medical Reserve Corps and the Southern Nevada Health District.
2. Waive any claims for compensation from the Southern Nevada Health District for any services performed related to my volunteer assignments with the Medical Reserve Corps.
3. Be responsible for any cost or treatment of any illness or medical condition that is not directly related to the performance of my volunteer assignments.
4. Maintain my current professional license, certification, or registration pertaining to my medical/public health duties with Medical Reserve Corps assignments.
5. Be bound by my professional Code of Ethics and Conduct in performing my duties as part of the Medical Reserve Corps.

Signature of Volunteer

Date

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