

Medina County Medical Reserve Corps  
**VOLUNTEER APPLICATION**



Please print clearly.

Today's date \_\_\_\_\_

**Personal Contact Information**

Title: Dr. Mrs. Ms. Mr. PhD. Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County of Residence \_\_\_\_\_

Primary Phone ( ) \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_

Email Address *\*(required if applicable)* \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender:  Male  Female

Driver's License Number *\*(required)* \_\_\_\_\_ State Issued *\*(required)* \_\_\_\_\_

DL Expiration Date *\*(required)* \_\_\_\_\_

**Work Contact Information**

Occupation \_\_\_\_\_ Specialty \_\_\_\_\_

Full time  Part time  Retired  Student

Professional License Current? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ NA State(s) where licensed to practice \_\_\_\_\_

License/Certification # *\*(required)* \_\_\_\_\_ Expiration Date \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone, Ext \_\_\_\_\_

Work Email \_\_\_\_\_

Are you an employee of a local health department?  Yes  No If so, which one? \_\_\_\_\_

What is the highest level of education you have completed? \_\_\_\_\_

Are you interested in volunteering for future events?  Yes  No

*\*This information is required for State database entry*

## Preferred Tasks

Please check off your *preferred* tasks during an emergency:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Assist clients with forms     | <input type="checkbox"/> Evidence preservation              | <input type="checkbox"/> Mental Health                |
| <input type="checkbox"/> Assist with client education  | <input type="checkbox"/> Evacuation                         | <input type="checkbox"/> Registration                 |
| <input type="checkbox"/> Assist with flu clinics       | <input type="checkbox"/> Greeter                            | <input type="checkbox"/> Security/Law Enforcement     |
| <input type="checkbox"/> Assist with health screenings | <input type="checkbox"/> Ham Radio Operator                 | <input type="checkbox"/> Strategic National Stockpile |
| <input type="checkbox"/> Computer Support              | <input type="checkbox"/> Immunizations                      | <input type="checkbox"/> Supply/Stock                 |
| <input type="checkbox"/> Data entry                    | <input type="checkbox"/> Infectious Disease/Contact Tracing | <input type="checkbox"/> Surveillance                 |
| <input type="checkbox"/> Decontamination               | <input type="checkbox"/> Interpreter Services               | <input type="checkbox"/> Trauma                       |
| <input type="checkbox"/> Developmental Disabilities    | <input type="checkbox"/> Injured or deceased animals        | <input type="checkbox"/> Triage                       |
| <input type="checkbox"/> Education and training        | <input type="checkbox"/> Laboratory capacity                |   |
| <input type="checkbox"/> Environmental health          |   |   |

No preference. You may call on me for any emergency.

Other, please describe \_\_\_\_\_

Do you speak or read a language other than English?  Yes  No If so which one? \_\_\_\_\_

Do you have any disaster/emergency response experience?  Yes  No If so, describe \_\_\_\_\_

Do you have any public health response experience?  Yes  No If so, describe \_\_\_\_\_

Do you have any disaster or crisis training experience?  Yes  No If so, describe \_\_\_\_\_

## Previous Training

Please check all current training or volunteer opportunities that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Advanced Disaster Life Support (ADLS)          | <input type="checkbox"/> American Red Cross                          |
| <input type="checkbox"/> Advanced Trauma Life Support (ATLS)            | <input type="checkbox"/> Disaster Medical Assistance Team            |
| <input type="checkbox"/> Basic Cardiac Life Support (BCLS)              | <input type="checkbox"/> Disaster Mortuary Operational Response Team |
| <input type="checkbox"/> Basic Disaster Life Support (BDLS)             | Other Certifications or training: _____                              |
| <input type="checkbox"/> Basic First Aid                                | _____  |
| <input type="checkbox"/> CERT training (Community Emerg. Response Team) | _____  |
| <input type="checkbox"/> Cardiopulmonary Resuscitation (CPR)            |  |
| <input type="checkbox"/> Critical Incident Stress Debriefing (CISD)     |  |
| <input type="checkbox"/> Hazmat Awareness Level training                |  |
| <input type="checkbox"/> Incident Command Structure (ICS)               |  |
| <input type="checkbox"/> Pediatric Life Support (PALS)                  |  |
| <input type="checkbox"/> Unified Command Structure (UCS)                |  |
| <input type="checkbox"/> WMD Awareness Level training                   |  |



## Registration with State System

To FULLY complete your application process with the Medina County MRC, each volunteer is required to register on the state database system, *Ohio Responds*. Ohio Responds is the state system used to alert, inform, and communicate with Ohio MRC volunteers. It is not only a notification system, but the Ohio Responds website, provides important resources and information for MRC volunteers.

**You must go online to <https://www.ohioresponds.odh.ohio.gov/> and register as a MRC volunteer. This is an important part of the application process as a MRC volunteer. In addition, registering on Ohio Responds provides volunteers with limited liability protection during events and activities.**

*As a Medina County MRC volunteer, I understand and will comply with the requirement to register as a MRC volunteer with Ohio Responds.* Name \_\_\_\_\_ Date \_\_\_\_\_

If the situation merits, (ie: no access to Internet/computer; physically unable) do you give the Medical Reserve Corps Coordinator permission to register your information with Ohio Responds ([www.ohioresponds.gov](http://www.ohioresponds.gov))?

Yes  No

## Availability

Are you part of an emergency/disaster plan with another organization or employer?  Yes  No

Circle those you are a part of:

American Red Cross

United Way

CERT (Community Emergency Response Team)

Other: \_\_\_\_\_

Are you willing to attend the mandatory Medical Reserve Corps training? (4 hours)  Yes  No

Please indicate when you are available for training:

- |                                    |                                  |                                    |                                  |
|------------------------------------|----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Sunday    | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Monday    | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Tuesday   | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Thursday  | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Friday    | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Saturday  | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |

Have you ever been convicted of a felony?  Yes  No

Have you ever been convicted of a misdemeanor?  Yes  No

Are you willing to submit to a background check if position merits?  Yes  No



Please print clearly.

**Health Information**

Describe any restrictions you have on activities: \_\_\_\_\_

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List all medications, vitamins, herbs, and over the counter drugs you usually take: \_\_\_\_\_

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Please list any allergies or other medical conditions that a physician would need to be aware of:

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**Emergency Contact Information**

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone ( ) \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_

May we call your emergency contact person in the event of an emergency?  Yes  No



The Medina County Health Department recognizes its responsibility to volunteer staff to assure fair and equal treatment and will not discriminate on the basis of color, religion, gender, age, sexual orientation, or national origin, or against any qualified handicapped individual or disabled veteran. I understand that I am applying for an unpaid volunteer position and that this is not an application for or contract of employment. I further agree that as a volunteer I may not accept payment for my services and that I will incur the cost of transportation. I understand that I will be required to complete the registration process with the state database system, Ohio Responds, by going to <https://www.ohioresponds.odh.ohio.gov/> and registering as a Medical Reserve Corps volunteer. I will also take an approved training every three years for liability protection purposes and to maintain active status as a Medical Reserve Corps volunteer. The statements made on the registration are true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation, omission of information, or misleading and incomplete data shall result in disqualification from consideration or dismissal as a volunteer. I understand that the Medina County Health Department reserves the right to disqualify or reject any volunteer.

X  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return this form to:**

**Jessica Miles, MEd, MCHES  
Medina County MRC Coordinator  
c/o Medina County Health Department  
4800 Ledgewood Drive  
Medina, Ohio 44256  
or  
Fax: (330) 723-9697**

Direct: (330) 662-0517

Email: [jmiles@medinahealth.org](mailto:jmiles@medinahealth.org)

Visit our website: [www.medinahealth.org](http://www.medinahealth.org)



For Office Use Only:

Date sent to volunteer: \_\_\_\_\_

Date received: \_\_\_\_\_

Date entered into database: \_\_\_\_\_