

Region IV Medical Reserve Corps of Southwest Washington

Serving: Skamania, Clark, Cowlitz, and Wahkiakum Counties

Volunteer Registration Form

Contact Information						
Emergency Worker Registration #:			(leave blank if unknown)			
County of Residence:						
Name (Last):	(First):	(Middle):	Photograph			
Employer:		Employer Phone:				
Home Address 1:						
Address 2:						
City:	State:	Zip Code:				
Home Phone: ()	Work Phone: ()					
Cell Phone: ()	Pager: ()					
E-Mail:	Radio Call Sign:	Date of Birth:			Blood Type:	Sex (M-F):
Driver's License No.:		Height:	Weight:	Eye Color:		
Physical Limitations or Disabilities (if any):			Natural Color of Hair:			
Person to Notify in Case of Emergency						
Name (Last):		(First):	Relationship:			
Day Phone: ()		Evening Phone: ()		Pager: ()		
Profession						
<i>Please identify your area of training and expertise:</i>						
<input type="checkbox"/> Certified Medical Assistant <input type="checkbox"/> Certified Nurse Assistant <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Assistant <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Emergency Medical Technician <input type="checkbox"/> Laboratory Technician <input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Medical Receptionist/Records <input type="checkbox"/> Mental Health Practitioner <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Paramedic <input type="checkbox"/> Pharmacist	<input type="checkbox"/> Pharmacy Assistant <input type="checkbox"/> Pharmacy Technician <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Podiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Radiology Technician <input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> Veterinarian <input type="checkbox"/> Veterinarian Assistant <input type="checkbox"/> Veterinarian Technician <input type="checkbox"/> Student <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____			
Licensure						
Licensing Board:		State:				
Highest Level of Licensure/Certification #:		Issue Date:	Exp. Date:			
Clinical Specialty/Area of Practice:						
Areas of Special Professional Expertise/Interest:						
Current credentialing through [name of institution(s)]:						
Currently, I have privileges to practice at [name of institution(s)]:						

Experience and Skills					
<i>Please check all that apply:</i>					
<input type="checkbox"/> Injections Adults	<input type="checkbox"/> Specimen handling	<input type="checkbox"/> Mental health	<input type="checkbox"/> Registration		
<input type="checkbox"/> Injections Children	<input type="checkbox"/> Triage	<input type="checkbox"/> Medical record review	<input type="checkbox"/> Radio/communications equipment		
<input type="checkbox"/> Injections Infants	<input type="checkbox"/> Medical diagnosis	<input type="checkbox"/> Administration/supervisor	<input type="checkbox"/> Clinic set-up/breakdown		
<input type="checkbox"/> Universal precautions	<input type="checkbox"/> Patient care	<input type="checkbox"/> Interviewing/investigating	<input type="checkbox"/> Data entry skills		
<input type="checkbox"/> Outbreak investigation	<input type="checkbox"/> First aid/CPR	<input type="checkbox"/> Education/teaching	<input type="checkbox"/> Crowd control		
<input type="checkbox"/> Contact tracing	<input type="checkbox"/> Medication distribution	<input type="checkbox"/> Purchasing/logistics	<input type="checkbox"/>		
<input type="checkbox"/> Respite caregiver	<input type="checkbox"/> Providing vaccination	<input type="checkbox"/> Staffing/scheduling	<input type="checkbox"/>		
Do you speak a foreign language? Yes <input type="checkbox"/> No <input type="checkbox"/>		Please list language(s):			
Speak fluently? Yes <input type="checkbox"/> No <input type="checkbox"/>	Reading/Writing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical Translation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Training and Orientation					
<i>To be announced</i>					
Immunization Status					
<i>Please indicate whether you have received any of the following vaccinations:</i>					
Vaccination				Year(s) Received	
MMRV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Incomplete <input type="checkbox"/>	
Anthrax	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Incomplete <input type="checkbox"/>	
	# of Vaccinations Received:				
Meningitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>		
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Incomplete <input type="checkbox"/>	
Smallpox	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	As a child only? <input type="checkbox"/>	
	# of Vaccinations Received:				
Comments:					

Risk Acknowledgement

I understand that participation in the Region IV Medical Reserve Corps of Southwest Washington may carry risks, including personal injury, from natural or man-made hazards, environmental conditions, diseases and other conditions that have the potential to cause injury. Being fully aware of the potential risks involved, by signing below, I hereby waive any and all legal rights I have or may have in the future to bring any claim or lawsuit against Clark County, Cowlitz County, Skamania County, Wahkiakum County, elected officials, employees, officers, or agents arising out of or connected with participating in the Region IV Medical Reserve Corps of Southwest Washington Program.

Worker's Compensation

This is a volunteer position. You are not considered to be an employee of either, Skamania, Clark, Cowlitz or Wahkiakum Counties. Therefore any personal injuries or exposures you may contract as a volunteer are not covered by Workers Compensation Insurance, also known as Industrial Insurance.

Medical Liability

Your volunteer activities will be covered by each counties General Liability policy. This coverage is afforded because you will be under the direct supervision and direction of the specific counties Director of Health.

Requirements

By submitting this registration form for membership in the Region IV Medical Reserve Corps of Southwest Washington, I understand and agree to the following:

- I must be at least 18 years of age.
- I must be photographed for volunteer staff identification purposes.

- I may be asked to complete the “Applicant Disclosure and Authorization for Background Inquiry” (this form gives your permission to conduct a criminal background check with the Washington State Patrol (WSP). Region IV MRC reserves the right to refuse applications based on the results of the WSP report/applicant disclosure form.
- I must have a valid driver’s license or state-issued identification.
- I am willing to volunteer for the purpose of providing healthcare services as directed by public health authorities in the event of an emergency.
- I am willing to be notified and activated when additional healthcare providers are needed to support the response to an emergency. If I am unable to respond, it will not affect my standing as a volunteer.
- Health care professionals must produce proof of licensure if needed for volunteer activities.
- I will participate in the required orientation and basic training.

I certify that the information on this form is correct to my best knowledge and belief.

Signature

Date

Please mail, fax, or bring in this registration form and a current copy of your professional license(s) to:

Clark County Health Department
 Attn: James Lanz/Medical Reserve Corps
 1601 Fourth Plain Blvd., PO Box 9825
 Vancouver, WA 98666-8825
 fax: (360) 759-7045

FOR AUTHORIZED OFFICIAL USE ONLY:

Registration received (date): _____
 Registration reviewed by: _____
 Interviewed on (date): _____
 Background check date: _____
 Background check results: _____
 Copy of license(s) (if any): _____
 Picture: _____
 Entered into database: _____
 Entered by: _____
