Quinnipiack Valley Health District
Medical Reserve Corps/Volunteer Application

PLEASE PRINT

Title: (Circle or X) Dr. Mr. Mrs. Ms. Miss Other-specify			
Last Name:	**Middle Initial:**	**First Name:**	**Date of Birth:**
Street Address	**Town**	**State and Zip code**	
Home phone:	**Work phone:**	**Cell phone:**	**Fax #:**
Primary email:		**Secondary email:**	
Name of Emergency Contact:	**Relationship:**	**Best telephone contact:**	
Do you have allergies? (Please identify.)		**In case of injury of illness, hospital preferred:**	
Languages spoken (other than English): **How fluent are you in other languages**?(circle or X) Fluent Well enough Slight **Would you be willing to act as an interpreter in an emergency?** YES NO			
What is your area of interest in terms of volunteering: (Choose all that apply) **Administrative** (examples: registration, greeting, patient flow) **Medical** **Safety/Security** **Logistics** **Medical** **Behavioral Health** **Data/Technology** **Wherever needed** **Other:** ________________________			
Do you hold any credentials? (Choose all that apply) **M.D./D.O**. **D.V.M./V.M.D** **D.D.S/D.M.D** **D.C.** **R.N**. **L.P.N.** **A.P.R.N./N.P** **EMT/Paramedic** **P.A.** **Pharmacist** **Psychiatrist/Psychologist** **Other Mental Health Provider** **Social Worker LCSW/LMSW/LBSW** **Other:**			
Professional License/Certification Title and ID number: 1. 2.	**Expiration date:**		
Medical personnel: do you have prescriptive authority?	YES NO		
Do you have a current driver's license?	YES NO		
Have you ever been convicted of a felony?	YES NO		
Would you be willing to submit to a background check?	YES NO		

I attest that the information provided in this application is correct and accurate to the best of my knowledge. I understand the QVHD/MRC may investigate and or verify the information I have provided. I do hereby give QVHD MRC permission to make inquiries regarding the information in this application. **I further understand that as a volunteer, I will not be paid for my services.** I also give my permission for the MRC to release personal information to local, state and federal emergency management agencies and other Health and Human Services agencies as needed.

Print name: ____

Signature: ____ Date: _________________________

You may e-mail (info@qvhd.org), fax (203 248-6671) or mail your completed application to the Quinnipiack Valley Health District, 1151 Hartford Turnpike, North Haven CT 06473. Telephone: 203-248-4528.

Revised 06/2017