



VOLUNTEER APPLICATION

Please print or type

Name				
Street Address (Mailing)				
City		State	Zip	
Home Phone	Work Phone		Cell Phone	
Email			Employer	
Type: Healthcare Professional: <input type="checkbox"/> Doctor (all categories) <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other _____	Type: Non Healthcare <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Requested means of communication: <input type="checkbox"/> Mail to above address <input type="checkbox"/> Mail to _____ <input type="checkbox"/> Email to above _____ Emergency Contact Name/Number: _____		
For All Healthcare Professionals: Please indicate License Number or Certificate/Registration Number Valid Y / N Expires: _____		Second Language _____	Third Language _____	
		State License Held _____	Degree(s) Obtained _____	
Level of Participation Desired: I prefer to be: <input type="checkbox"/> ACTIVE Receives notifications of ALL training opportunities, training drills & exercises, emergency events, as well as non-emergency volunteer opportunities <input type="checkbox"/> LIMITED Receives only notification of training drills and exercises and all emergency events <input type="checkbox"/> EMERGENCY ONLY Receives notification of only major emergency events <i>NOTE: All volunteers are required to take the orientation training and the training from CCDPH. Additional training is optional for Limited and Emergency Levels at this time.</i>				
Have you ever been convicted of a felony? Yes No A misdemeanor (other than a traffic violation) Yes No If yes, please explain: _____				
A Criminal Background Check may be required of some volunteers: <input type="checkbox"/> YES, I agree that a background check may be performed. Birthdate ___/___/___ Other Names _____ <input type="checkbox"/> NO, I do not wish to have a background check performed (Refusal of a background check does not automatically eliminate you from consideration for volunteer service.)				
Which Community would you prefer to serve in? Circle Choice				
Unincorporated Maine Twp Morton Grove Des Plaines Niles Park Ridge Rosemont Lincolnwood ANY	<table border="1"> <tr> <td> Valid D/L? Yes / No State: _____ D/L# _____ </td> </tr> </table>			Valid D/L? Yes / No State: _____ D/L# _____
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<table border="1"> <tr> <td> AGREE TO DEPLOY OUTSIDE OF AREA Y / N </td> </tr> </table>			AGREE TO DEPLOY OUTSIDE OF AREA Y / N	
AGREE TO DEPLOY OUTSIDE OF AREA Y / N				
Signature			Date	

Privacy Act Statement

This information is requested by the Maine Township Regional Medical Reserve Corps for the purpose of organizing volunteers and staff to respond to area emergencies, disasters or public health emergencies. It will not be utilized or released for any other purpose without your express written permission unless required by law.

<p>Please email to: maine-mrc@sbcglobal.net Fax: 847/297-1335 Or mail to: R. Cohen, Director, Maine Twp Regional MRC 1700 Ballard Rd, Park Ridge, IL 60068</p>	<p>08/31/06</p>
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