



**Training**

Have you completed any of the following training in the past 3 years?

- Community First Aid and Safety      Expiration Date:
- Adult, Child and Infant CPR      Expiration Date:
- Any other Red Cross or AHA Trainings (specify)      Expiration Date:
- Basic Emergency or Disaster response training
- Basic Incident Command System Course
- Other, please describe

**Personal References**

Please list two people who know your qualifications and/or background and experience. Do not list relatives or supervisors. Reference checks will be conducted by phone during regular business hours. Please notify individuals that the Douglas County Medical Reserve Corps will be contacting them regarding your interest in becoming a volunteer.

Name	Relationship to you
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Phone Work	Home	Known how long?
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Name	Relationship to you
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Phone Work	Home	Known how long?
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Have you ever been convicted of a crime?    Yes    No

If yes, please explain:

My signature below authorizes the Lawrence-Douglas County Health Department (hereinafter "Health Department") to conduct a background investigation and authorizes the release of information from third parties to the Health Department in connection with my application to be a Douglas County Medical Reserve Corps Volunteer. This investigation and release of information may include obtaining information from employers, educational institutions, licensure authorities, personal references identified herein, other individuals and other sources. This investigation may also include a criminal background check regarding prior convictions or other applicable criminal history.

I hereby waive my right of access to any such information and without limitation hereby release the Health Department, the City of Lawrence, Douglas County, and their respective employees, agents, and board members, together with any individual, licensure authority, agency, business or corporation that provides information or documents to the Health Department, from any liability in connection with its release of such information to, or use of such information by, the Health Department.

I certify that I have made true, correct and complete answers and statements on this Application and that I have not withheld anything which, if disclosed, would unfavorably affect the Health Department's consideration of this Application. I agree to notify the Health Department immediately if there is a change in my licensure status.

**Please Print**

Name	Signature	Date
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**For Office Use Only:**

License Verification State	Number	Expiration Date
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Verified by:      Date:

Has license ever been revoked or suspended?

Interview Date: