



## VOLUNTEER APPLICATION

**Volunteers must be 18 years of age or older.**

<b>Name</b>			
Last	First	Middle	Nickname
<b>Address</b>			
Street	City	State	Zip
<b>Phone</b>			
Home	Work	Mobile	E-mail
<b>Emergency Contact Information</b>			
Name	Relationship		Phone
Street	City	State	Zip
<b>Present Employer</b>			
Company	Position	Phone	Email
<b>Address</b>			
Street	City	State	Zip
<b>Previous Employment</b>			
Company	Position	Mo/Yr	
Company	Position	Mo/Yr	
<b>Volunteer Experience</b>			
Organization	Position	Mo/Yr	
Organization	Position	Mo/Yr	
<b>Education</b>			
School	Degree/Specialty	Yr Completed	
School	Degree/Specialty	Yr Completed	
<b>Licenses, Certifications, Specialized Skills or Foreign Languages</b>			
<input type="checkbox"/> Medical License (specify type)			
<input type="checkbox"/> Nursing License (specify type)			
<input type="checkbox"/> EMT/Paramedic License (specify type)			
<input type="checkbox"/> Mental Health/ Social Work			
<input type="checkbox"/> Other (specify type)			
<input type="checkbox"/> Certifications (List or Describe)			
<input type="checkbox"/> Specialized Skills (List or Describe)			
<input type="checkbox"/> Foreign Language(s) 1.		<input type="checkbox"/> Speak	<input type="checkbox"/> Read
<input type="checkbox"/> Foreign Language(s) 2.		<input type="checkbox"/> Speak	<input type="checkbox"/> Read
		<input type="checkbox"/> Write	<input type="checkbox"/> Write
<b>Return completed application to:</b>			
<b>Douglas County Medical Reserve Corps</b> <b>Lawrence-Douglas County Health Department</b> <b>200 Maine, Suite B</b> <b>Lawrence, KS 66044</b>		<b>Phone: (785) 843-3060</b> <b>Fax: (785) 843-3161</b> <b>Email: <a href="mailto:mrc@ldchealth.org">mrc@ldchealth.org</a></b>	

**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: