Chesapeake Medical Reserve Corps
Volunteer Application

Date: ______________

You may mail, fax, or e-mail this form or call to apply:

Chesapeake Health Department **Attn: Becky Washburn** **Phone: (757) 382-8719** **Fax: (757) 547-0298**
748 North Battlefield Boulevard Medical Reserve Corps Program Coordinator
Chesapeake, VA 23320-4941 E-mail: Rebecca.Washburn@vdh.virginia.gov

☐ **YES!** I will be available to volunteer my services in a medical emergency or to assist our community with ongoing public health needs. Please add my name to the Chesapeake Medical Reserve Corps (CMRC) database.

☐ **YES!** I authorize the CMRC to do a Police Background Investigation, check my professional credentials and verify the information on my application.

Please note that all contact information will be kept strictly confidential. It will be used only in an event of an emergency, and to inform the willing participant of voluntary training opportunities, meetings and exercises that are specific to their CMRC job description.

Name (please print): ____
Date of Birth: _______________ Place (City/County/State/Country) _________________________________
Physical Home Address (not P.O. Box): ____
City/State/9 digit Zip: ____
Are you a US citizen? Yes ___ No ___ Are you a legal immigrant? Yes ____ No _______
Status (please check): Married ______ Single _______ Divorced _______ Widowed _______________
Race: White ___ Black ___ Asian/Pacific Islander ___ Am Indian/Alaskan ___ Hispanic ___ Other _____
in your household: _____ Head of household? Yes ___ No ___ # of Pets ____ Type(s) _________________

Profession: MD __ Phys Asst ___ RN ___ LPN ___ CNA ___ C Nurse Prac ____ R Phar ___ Phar Tech ___
Dentist ___ Dental Tech ___ Veterinarian ____ Vet Tech ____ Psychologist ___ Psychiatrist ____
School Counselor ____ EMT/EMS ____ Resp Therapists ____ Lab Tech ___ Other Mental Hlth __________
Public Hlth (type) _____ Security _____ Fire Fighter ____ Logistics _____ Finance _____ Arbitration ______
Crisis/Shock Recovery Specialist ____ Admin Support ____ Public Communications ____ Other Support ___

Employed? FT ____ PT ____ Ret ____ Self-employed Student _____ Employer: _________________________
Hosp or Hlth Care Facility (name)__________________________ Address: _____________________________
City/State/Zip: ____
Affiliated W/ other Volunteer Organization? Yes ____ No ____ Name ______________________________

ID Check/Copy: Driver's License __________ Employment ID ___________ Other Licenses/Cert ____________
MD ___ RN ____ PSY ___ CPR ___ CPR/AED___ Amateur Radio _______ FEMA Cert _________________
Contact Info: Day Phone: ______________ Evening Phone: _____________ Cell Phone _________________
E-mail: ____________________________________ Alternate E-mail: ___________________________________

Best way to contact you in an emergency? __________________ **non-emergency** ____________
Enroll me in the VA Health Alert Network (HAN): Yes _____ No _____
In case of emergency contact name: ____
Relationship: _________________ Phone: ____________ Alt Phone: _______________________
Address/City/9 digit Zip: ____

Availability for the CMRC unit (Please check all applicable): Yearly _____ Quarterly ________
Monthly ______ Wkly _______ As needed ______ Emergency ____ Drill ____ Event _____
Team Leader _____ Recruiter ____ Event Planner ___ Marketing ______ Board Member ___________
Instructor ______ CMRC Office ____ Newsletter Assembly ______ Community Outreach ____
Phone Tree ____ Mailing Assembly _______ Health Education ____ Member Outreach ____ Other ___

I will complete the required CMRC basic training within: 3 months _____ 6 months _____ 1 Year ___

Signature: ______________________________________ **Date:** ____________________________