

**Defiance County Medical Reserve Corps
Volunteer Application**

Date of Application _____ Date of Birth _____

Name _____
Last First MI

Home Address _____
Street City State Zip

E-Mail Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Place of Employment _____

Occupation _____ Full Time Part Time

Retired Student

U.S. Citizen? _____ Yes _____ No

Please list areas of Licensure/Certification _____

Please list areas of expertise, special skills, training, etc. _____

Please list other volunteer affiliations _____

Emergency Contact Information

Name _____
Last First MI

Home Address _____
Street City State Zip

Relationship _____

Home Phone _____ Work Phone _____

I hereby certify that all the information on page one is accurate and correct and I hereby make application for membership in the Defiance County Medical Reserve Corps. I understand that I am applying for a volunteer position and this is not an application for, or contract of, employment.

I understand that every attempt will be made to reduce risks to volunteer, however, some risks may be present during a public health emergency and I agree to assume my own risk as a volunteer.

Signature of Applicant

Date

PHOTO PERMISSION:

Yes, _____, I give my permission to be interviewed and/or photographed for publicity purposes. I understand that this information may appear publicly in a newspaper or other advertising media.

No expiration on this permission unless notified.

Signature

Date

BACKGROUND CHECK:

The Defiance County Medical Reserve Corps requires that all volunteers should undergo a background check. This is done for safety and security concerns of all citizens of the county and is not meant to be an intrusion. **You may opt out of this without affecting your status as an MRC volunteer.**

_____ Yes, I agree to have my background checked.

_____ No, I am opting out of having my background checked and it will not affect my MRC status.

CREDENTIALS VERIFIED:

I give my permission to have my credentials verified.

Signature

Date

STATE OF OHIO DATA BASE:

I give my permission to have my name added to the State of Ohio Data Base for liability purposes.

Signature

Date

Please return completed application to: Cheryl Kehnast, LSW, RN
Defiance County Health Department
1300 East Second Street
Suite 100
Defiance, Ohio 43512