

Flagler County Medical Reserve Corp Volunteer Application



As a candidate for a volunteer position with the Flagler County MRC (FCMRC), I am willing to furnish information for use in determining my qualifications. I authorize release of any and all information that you may have concerning me, including information of a confidential or privileged nature. I understand that for security purposes a basic background check will be conducted to determine my eligibility utilizing Florida Department of Health Chapter 110 Volunteer application requirements.

PLEASE PRINT CLEARLY. IT IS IMPORTANT THAT YOU ANSWER ALL QUESTIONS ON THIS APPLICATION FULLY AND ACCURATELY.

Personal Contact Information

Dr. Mr. Ms. Mrs. Rev. (Circle one)
Name: _____

Last	First	Middle	Maiden Name/Other Names Used
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Address: _____

Street Address	City	State	Zip Code	County
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Driver's License: _____ Expiration: _____
State and Number Date

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Pager: (____) _____

Fax: (____) _____

How do you prefer to be contacted? Home Cell Work Page E-mail (Please, circle one)

Please send e-mails to: Home Work

E-Mail: _____
Work e-mail Home e-mail

Work Information

Occupation: _____ Employer: _____

Address: _____

Street Address	City	Sate	Zip Code	County
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Previous Employer: _____ Occupation: _____

Address: _____ Employment Dates: _____
City Sate Zip Code

Education and Military Experience

Education: High School/College/Graduate School/Other _____ Year Graduated: _____
(Circle highest level completed)

School Name: _____ Location: _____
City State

Type of Degree: _____ Major/Specialization: _____

Military Service Branch: _____ Dates of Service: _____

For Students, please complete the following information:

School Name: _____ Type of Degree: _____

Major/Specialization: _____ Expected Completion Date: _____

Health & Insurance

In case an emergency happens to me, please contact:

Name: _____ Relationship: _____

Daytime Phone: (____) _____ Evening Phone: (____) _____

Medical Insurance: _____ Contact Number: (____) _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder _____ - _____ - _____
Name Social Security Number

Do you have any personal health issues that would impact your ability to volunteer? YES NO

For example: allergies, medication issues, disabilities, special needs, being treated for a medical condition, etc If yes, please list here or speak personally with the MRC coordinator.

Training and Licensure

Please check all for which you are trained or are training for:

- | | | | |
|------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Physician Specialty: | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Nurse's Aide | <input type="checkbox"/> Medical Assistant |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Mental Health Professional | <input type="checkbox"/> Respiratory Technician |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> EMT/Paramedic | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Veterinary |
| <input type="checkbox"/> Health Administration | <input type="checkbox"/> Maintenance/Supply | <input type="checkbox"/> Medical Records | <input type="checkbox"/> Home Health Aide |
| <input type="checkbox"/> Other: _____ | | | |

Do you have a professional FL license in any of the above areas? **Y N Active / Inactive**

License number: _____ Expiration: ____/____/____

Do you have prescriptive authority? **Y N**

MD-Hospital Affiliation (s) _____

Are you a Foreign Medical Doctor? **Y N**

If yes, what is your current U.S. medical certification? _____

Certifications and Other Training (check any that apply)

Certification	Most Recent Date	Certifying Agency
<input type="checkbox"/> CPR (Health Professional)	____/____/____	_____
<input type="checkbox"/> CPR (Friends & Family)	____/____/____	_____
<input type="checkbox"/> First Aid	____/____/____	_____
<input type="checkbox"/> AED	____/____/____	_____
<input type="checkbox"/> CERT	____/____/____	_____
Other Certifications		
_____	____/____/____	_____
_____	____/____/____	_____

Do you speak other language (s) than English?

Are you willing to volunteer as an interpreter? Yes No

Training (check any that apply)

- Disaster Training
- Mental Health Training
- Blood borne Pathogens & Standard Precautions
- Incident Command System
- Epidemiology
- Bioterrorism
- Terrorism & Emergency Response to Terrorism
- Military Medical
- Other training _____

Volunteer Experience

Please list any current or previous volunteer activities:

Why do you wish to volunteer with the FCMRC Unit?

I hereby authorize the FCMRC, its designee, or agent, to investigate my past or current activities and to receive full and complete disclosure of all records relating to me and my past employment, criminal or traffic reports or arrest reports or investigations.

I understand that the FCMRC at times handles sensitive or confidential information; the disclosure of which could adversely affect a criminal investigation and in some instances may be a violation of law. I agree not to disclose any information obtained by me while engaged in my volunteer duties unless specifically authorized in advance by a city supervisor. I understand that my failure to comply with this paragraph will result in my removal from the volunteer program.

I hereby indemnify and hold the FCMRC harmless from and against, any and all liability, for any injury to my property or myself or any other damage or cause of action, which may arise while I am engaged in volunteer activities with the County. I agree that the County will not be responsible for any activities, liability, suits or damages which may occur during or as a result of my volunteer status with the County, which occur outside the scope of the responsibilities and duties assigned to me.

The statements made by me in this application are true and complete to the best of my knowledge. I understand that any misstatements or material omission on this application will be considered sufficient cause to disqualify me for volunteer opportunities with the FCMRC.

SIGNATURE: _____

DATE: _____

Flagler County Medical Reserve Corps

Please read the following statements carefully. Sign and return this form with your completed application.

Automatic Disqualifiers

The Flagler County Medical Reserve Corps will NOT consider the application of any individual who:

1. Has been convicted of a felony or any offense that would be a felony if committed in Florida.
2. Has used illegal drugs within the last six months.
3. Has sold marijuana or other illegal drugs within the last two years.
4. Has falsified his or her application, including the omission of required information.

Discretionary Disqualifiers

The following disqualifiers MAY, upon review, makes you ineligible for the Flagler County Medical Reserve Corps:

1. A physical or mental disability that would substantially impair an individual's ability to perform his or her duties with a reasonable accommodation.
2. Misuse or abuse of alcohol or prescription drugs.
3. A demonstrated unwillingness to honor fiscal contracts or just debts.
4. Any conduct or pattern of behavior that would tend to disrupt, diminish or otherwise jeopardize public trust in a public position.
5. Misdemeanors
6. Loss of professional licensure
7. Revoked drivers' license

I have read and understand the above disqualifiers. Please consider my application for participation in the Flagler County Medical Reserve Corps.

Signature: _____ **Date:** _____



VOLUNTEER ENROLLMENT APPLICATION

Name _____ (Last) _____ (First) _____ (Middle)

Mailing Address _____ City _____ State _____ Zip _____

Work Telephone _____ / Home Telephone _____ / Cell Phone _____

Email: _____
 _____ Emergency Contact Telephone Number _____

What type of volunteer position are you interested in? _____

List any professional license, registration, or certificate you currently possess (include certificate/license number): _____

List any special skills, interests, or hobbies: _____

List any special considerations or needs: _____

List two personal references not related to you whom you have known for more than one year:

NAME	NAME
ADDRESS	ADDRESS
CITY/STATE ZIP	CITY/STATE ZIP
PHONE	PHONE

List your most recent volunteer or employment experience:

EMPLOYER _____ COMPLETE MAILING ADDRESS _____ TELEPHONE _____

JOB TITLE _____ DATES OF VOLUNTEER/EMPLOYMENT _____

Specify the days and time frames you are available to volunteer: _____

Day of Week	Hours	Day of Week	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?

Yes _____ No _____ If answer is yes, please explain (including types of offenses and dates): _____

It shall be a misdemeanor of the first degree to fail to disclose, by false statement, misrepresentation, impersonations or other fraudulent means, any material fact used in making a determination as to a person's qualifications to work as a volunteer.

I understand that, to protect persons served by the department, a routine check through law enforcement, license bureaus, agency files, and references may be made. I understand that a criminal offense will not automatically exclude me from all volunteer positions; however, certain convictions will exclude me from volunteering in some positions. I understand that if I answered no to the criminal offense question on the front of this application and a record should be obtained, it will prevent me from volunteering for the department regardless of the offense. I understand upon submission of this application it becomes public record.

I understand and agree that all information as it relates to persons served by the department is to be held confidential in compliance with Florida Statutes. All information that should come to my attention and knowledge as privileged and confidential will not be disclosed to anyone other than authorized personnel and that I shall conduct myself in accordance with the departmental security policies. I understand that failure to comply may result in criminal prosecution.

I affirm that all information on this application is true and correct.

_____/_____/_____
Signature Date

**INTERVIEWER'S COMMENTS
(For Agency Use Only)**

Date of Interview: ____/____/____ Interviewer's Name: _____

Screening Required: Yes _____ No _____ Date Screening Completed: _____

Date Orientation Completed: _____

**WORK ASSIGNMENT
(For Agency Use Only)**

Program Location

Supervisor Date of Placement

It is unlawful for an employer to refuse or deprive any individual of volunteer opportunities because of race, color, religion, sex, national origin, age, marital status, or handicap. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, 2009 Apalachee Parkway, Suite 100, Tallahassee, Florida 32301-4857.

