WASHINGTON REGION 3 MEDICAL RESERVE CORPS

VOLUNTEER APPLICATION FORM
PACIFIC COUNTY

PERSONAL INFORMATION

Volunteer Name: _____ Home Phone: _____

Birthdate: _____

Office Phone: _____Pager: _____ Cell Phone: _____

Address: _____ City _____ Zip _____

Email Address: _____Driver's License Number: _____

Affiliations? (eg., school, agency, clinic):_____

EXPERIENCE

Current (Most Recent) Employer: _____Position: _____

Address _____ Phone: _____

- ❒ Full Time
- ❒ Part Time
- ❒ Retired
- ❒ Other: _____

PROFESSIONAL INFORMATION: (mark or circle all that apply)

- ❒ Physician: Area of Specialty:_____ Board Certified? Yes No
- ❒ Nurse: RN LPN Nurse Practitioner Do you have prescriptive authority? Yes No
  Area of Specialty:_____
- ❒ Emergency Medical Technician
- ❒ Paramedic
- ❒ Pharmacist
- ❒ Mental Health Practitioner Psychologist Other:_____
- ❒ Social Worker
- ❒ Physician Assistant
- ❒ Nurse Assistant
- ❒ Medical Assistant
- ❒ Dentist
- ❒ Veterinarian
- ❒ Environmental Health Specialist
- ❒ Health Educator
- ❒ Health Technician Type_____
- ❒ Public Relations
- ❒ Media/Communications
- ❒ Clergy *Denomination*:_____
- ❒ Other_____

Professional License Type/Number: _____Expiration Date: _____

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OTHER SKILLS

Are you CPR certified? Yes No
Are you AED certified? Yes No
Are you first aid certified? Yes No
Other?_____

Language fluency, besides English _____

Please list any other special disaster training, certification, or skills that you would like us to be aware of:
_____
_____
_____

PRIORITIES

In the event of an emergency or disaster what would your first priority be? Please rank in order of priority, with 1 being the highest priority for you:

Family/Home _____
Work _____
Volunteer Activities _____
Other: _____ _____

Would you be willing to volunteer your services in other counties within Region 3 during disasters? If so, please check all that apply: ☐ Grays Harbor ☐ Lewis ☐ Mason ☐ Pacific ☐ Thurston

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Out of Area Contact: _____ Relationship: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

_____ _____
SIGNATURE **DATE**

Please send your completed application packet to:
Pacific County Public Health & Human Services Department, POB 26, South Bend, WA 98586