



Newaygo County Emergency Services Volunteer Application



****Save this form to your computer BEFORE completing it.**
**Once you have saved it, open the form from your computer
 and fill that out. Save that form again with that data entered in.
 You will then be able to attach it to an e-mail or print it out.****

Which organization(s) are you interested in joining?

Date of Application: _____

- Community Emergency Response Team (CERT)
- Medical Reserve Corps (MRC)
- Radio Amateur Civil Emergency Service (RACES)
- Emergency Management Support Team (EMST)

Personal Information

Name: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email Address: _____

Availability: Days Nights Weekends

Foreign Language: _____ Read Write Speak Interpret

Emergency Contact (Person who can be notified in case of personal emergency)

Name: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Additional Information

Yes No

- Are you willing to travel and volunteer outside of your county?
- Are you willing to provide transportation service?
- Do you have the ability to communicate using sign language?
- Have you been immunized against Smallpox?
- Do you have any special needs/restrictions? If so, explain.
 Comment: _____
- In the event of an emergency, are you committed to any other organizations or Institution by virtue of employment or volunteerism? If so, explain.
 Comment: _____
- Do you have particular expertise and agree to be available for consultation or response throughout the state? _____



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Experience: Do you have any of the following skills?

- | | | |
|--|---|--|
| <input type="checkbox"/> CPR | <input type="checkbox"/> Inventory Supplies/Equipment | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Clerical Work | <input type="checkbox"/> Loading/Shipping | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Computer Networking | <input type="checkbox"/> Leadership | <input type="checkbox"/> Volunteer Services |
| <input type="checkbox"/> Computer Skills | <input type="checkbox"/> Amateur Radio | <input type="checkbox"/> Management |
| <input type="checkbox"/> Counseling Skills | <input type="checkbox"/> Office Management | <input type="checkbox"/> Fatality Management |
| <input type="checkbox"/> Crowd Management | <input type="checkbox"/> Phone Receptionist | <input type="checkbox"/> First Aid |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Health Care Professional | <input type="checkbox"/> Food Service |
| <input type="checkbox"/> Desktop Support | <input type="checkbox"/> Search and Rescue | <input type="checkbox"/> Foreign Language |
| <input type="checkbox"/> Elderly/Disabled Assistance | <input type="checkbox"/> Interviewing | |
| <input type="checkbox"/> Other: _____ | | |

Comment: _____

Medical Training/Continuing Education: Check areas where you have completed training.

- | | |
|---|--|
| <input type="checkbox"/> Advanced Cardiac Life Support | <input type="checkbox"/> Hazardous Materials Training |
| <input type="checkbox"/> Advanced Trauma Life Support | <input type="checkbox"/> Hospital Preparedness |
| <input type="checkbox"/> Basic Disaster Life Support (BDLS) | <input type="checkbox"/> Incident Command Training (ICS) |
| <input type="checkbox"/> Basic Cardiac Life Support (BCLS) | <input type="checkbox"/> National Incident Management System |
| <input type="checkbox"/> Blood Borne Pathogens | <input type="checkbox"/> Isolation and Quarantine |
| <input type="checkbox"/> CBRNE or Weapons of Mass Destruction | <input type="checkbox"/> Critical Incident Stress Debriefing |
| <input type="checkbox"/> CPR/AED | <input type="checkbox"/> Pediatric Advance Life Support |
| <input type="checkbox"/> Triage | <input type="checkbox"/> Vaccination Administration |
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Strategic National Stockpile (SNS) |
| <input type="checkbox"/> Alternate Care Centers | <input type="checkbox"/> Neighborhood Emergency Help Centers |



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Health Care Professionals – Please complete the following sections if you are interested in the MRC Professional Licensure, Certification, Specialties, and Experience.

Name on license/Certification: _____

State on license/Certification: _____ License/Certificate Number: _____

Specialty within the above license: _____

Do you have prescriptive authority: Yes No

Experience: Check the areas where you have the following skills/designations.

- | | |
|--|---|
| <input type="checkbox"/> DCM (Doctor of Chiropractic Medicine) | <input type="checkbox"/> PharmD (Doctor of Pharmacy) |
| <input type="checkbox"/> DDS, DDM (Dentist) | <input type="checkbox"/> Pharmacy Assistant |
| <input type="checkbox"/> DO (Doctor of Osteopathy) | <input type="checkbox"/> Pharmacy Technician |
| <input type="checkbox"/> DPM (Podiatrist) | <input type="checkbox"/> Registered/Licensed Pharmacist |
| <input type="checkbox"/> DVM (Veterinarian) | <input type="checkbox"/> Veterinary Technician |
| <input type="checkbox"/> MD (Medical Doctor) | <input type="checkbox"/> Environmental Health Specialist |
| <input type="checkbox"/> OD (Optometrist) | <input type="checkbox"/> Epidemiologist |
| <input type="checkbox"/> PA (Physician Assistant) | <input type="checkbox"/> Health Educator |
| <input type="checkbox"/> CRNA (Nurse Anesthetist) | <input type="checkbox"/> Health Officer |
| <input type="checkbox"/> LPN (Licensed Practical Nurse) | <input type="checkbox"/> Health Planner |
| <input type="checkbox"/> NP (Nurse Practitioner) | <input type="checkbox"/> Industrial Hygienist |
| <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Microbiologist |
| <input type="checkbox"/> Nursing Asst/Patient Care Associate | <input type="checkbox"/> Pastoral Care Professor |
| <input type="checkbox"/> RN (Registered Nurse) | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Dental Technician | <input type="checkbox"/> Public Information Officer |
| <input type="checkbox"/> EMT (Emergency Med Tech) | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Funeral Director/Mortician | <input type="checkbox"/> Student of Health Professions |
| <input type="checkbox"/> Information Technician (IT) | <input type="checkbox"/> Translator/Linguist |
| <input type="checkbox"/> Laboratory Tech | <input type="checkbox"/> PT/OT (Physical/Occupational Therapist) |
| <input type="checkbox"/> Paramedic | <input type="checkbox"/> Certified/Licensed Social Worker (CSW, LCSW, Other) |
| <input type="checkbox"/> Surgical Technician | |

Comments/Details: _____



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As a volunteer with the Medical Reserve Corps, or the Community Emergency Response Team, I may be called upon to assist in the event of an emergency or disaster. I agree to attend an educational program to explain my role in disaster preparedness; I may be assigned duties based on my level of training and experience. I understand that submitting this application does not guarantee acceptance into the Medical Reserve Corps, or the Community Emergency Response Team. The information contained in this application is, to the best of my knowledge, truthful. I agree to serve my fellow citizens to the best of my ability.

___ I agree with this statement

Signature: _____

APPLICANT BACKGROUND CHECK CONSENT

Organization: Newaygo County Emergency Services

Applicant's Name: _____
(First) (Middle) (Last)

Date of Birth: ____ / ____ / ____ Driver's License Number: _____ State: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize and give consent for the above named organization to obtain information regarding myself. This includes the following:

- Criminal Background Records/Information
- Sex Offender Registry Checks
- Driving Records
- Addresses

I the undersigned, authorize this information to be obtained, either in writing or via telephone, in connection with my volunteer application. Any person, firm or organization providing information or records in accordance with this authorization is released from any and all claims of liability for compliance. Such information will be held in confidence in accordance with the organization's guidelines.

Signature: _____ Date: ____ / ____ / ____

Witness: _____ Date: ____ / ____ / ____

Once you have completed this form you can save it to your computer and attach it to an e-mail and send it to NewaygoES@co.newaygo.mi.us or print it and bring it to the Emergency Services Office in White Cloud