



**Weber Morgan Medical Reserve Corps (MRC)**  
**477 23rd Street**  
**Ogden, Utah 84401**  
**801-399-7100 or 801-399-7128**

## VOLUNTEER APPLICATION

The following volunteer application includes personal identification and contact information, as well as information about your education and experience. You can also specify the areas for which you wish to volunteer. This information is secure and will be used only to contact you about volunteer opportunities.

**Today's Date:** \_\_\_\_\_

### Demographics

\*Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*County in which you reside: Weber / Morgan Circle one

\*Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_

1<sup>st</sup> Email Address: \_\_\_\_\_ 2<sup>nd</sup> Email Address: \_\_\_\_\_

### Emergency Contact Information

\*Primary Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*1<sup>st</sup> Phone Number: ( ) \_\_\_\_\_ 2<sup>nd</sup> Phone Number: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

1<sup>st</sup> Phone Number: ( ) \_\_\_\_\_ 2<sup>nd</sup> Phone Number: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

### Employment/ Specialty Information

Are you employed?  Yes  No

\*Employer: \_\_\_\_\_ Specialty: \_\_\_\_\_

### Utah Healthcare License Information

**Do you have a professional healthcare license in Utah?**  Yes  No

If not licensed in Utah, from which state do you hold a license? \_\_\_\_\_

**Do you want to be credentialed to volunteer at a health care facility in a crisis?**  Yes  No

To register as a licensed volunteer, you must have a valid license. Enter your license number and your name as it appears on your license. You can look up your license number at the [Utah Division of Occupational and Professional Licensing](#) web site.

Fields marked with an asterisk \* are required.

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

\*License Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

DD/MM/YYYY

DD/MM/YYYY

**\*License type (choose one only):**

**Type I** - License is active and unencumbered. Active privileges in a Health Care Facility

**Type II** - License is active and unencumbered. Active clinical practice in a non-Health Care Facility setting



Please check all that apply

**Type III** - License is active and unencumbered; not actively practicing at this time.

**Type IV** - Previously held an active and unencumbered license, but currently expired

**\* Has your professional license ever been revoked, suspended or investigated?**

Yes

No

**If yes, please explain. You may attach a separate sheet of paper if you desire.**

**\* Do you maintain your own Professional Liability Insurance?**

Yes

No

Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

## Training

ICS=Incident Command System

### Disaster Management Training

**I have the following:**

ICS 100 - Intro to ICS

ICS 200 - ICS Initial Actions

ICS 700 - Nat. Incident Management

ICS 800 - Nat. Response Plan

### Other Related Training

**I have the following:**

CPR Certification

CDLS (core disaster life support)

BDLS (basic disaster life support)

Other \_\_\_\_\_

Language Skills other than English: \_\_\_\_\_

What other training, skills and certifications would you like us to know about?

|  |
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Please check all that apply

| <input type="checkbox"/><br><b>Public Health</b> Mark your choice or specialty below | <input type="checkbox"/><br><b>Physician/Advance Practice</b> Mark your choice or specialty below | <input type="checkbox"/><br><b>Nursing</b> Mark your choice or specialty below | <input type="checkbox"/><br><b>Mental Health</b> Mark your choice or specialty below | <input type="checkbox"/><br><b>Support Personnel</b> Mark your choice or specialty below | <input type="checkbox"/><br><b>Other Licensed/Clinical Personnel</b> Mark your choice or specialty below |
|--|---|--|--|--|--|
| <input type="checkbox"/> Case Investigation  | <input type="checkbox"/> MD-Specialty _____   | <input type="checkbox"/> CNA   | <input type="checkbox"/> Crisis Counselor  | <input type="checkbox"/> Administrative  | <input type="checkbox"/> Clinical Laboratory Specialist  |
| <input type="checkbox"/> Epidemiology  | <input type="checkbox"/> Dentist (DDS)  | <input type="checkbox"/> CRNA  | <input type="checkbox"/> Mental Health Worker  | <input type="checkbox"/> Clerical  | <input type="checkbox"/> Clinical Laboratory Tech  |
| <input type="checkbox"/> Health Education  | <input type="checkbox"/> Veterinarian (DVM)   | <input type="checkbox"/> LPN   | <input type="checkbox"/> Psychiatrist  | <input type="checkbox"/> Dietary Services  | <input type="checkbox"/> EMT Basic   |
| <input type="checkbox"/> Home Visiting   | <input type="checkbox"/> Physician Assistant  | <input type="checkbox"/> RN-Specialty _____                                    | <input type="checkbox"/> Psychologist  | <input type="checkbox"/> Facilities  | <input type="checkbox"/> EMT Intermediate  |
| <input type="checkbox"/> Immunization/ Prophylaxis Clinic                            | <input type="checkbox"/> Advance Practice RN  | <input type="checkbox"/> Critical Care   | <input type="checkbox"/> Social Worker   | <input type="checkbox"/> Ham Radio Operator  | <input type="checkbox"/> EMT Paramedic   |
| <input type="checkbox"/> Medical Phone Center  | <input type="checkbox"/> Vet Assistant  | <input type="checkbox"/> Emergency   | <input type="checkbox"/> Substance Abuse Counselor                                   | <input type="checkbox"/> Housekeeping Staff  | <input type="checkbox"/> Medical Assistant   |
| <input type="checkbox"/> Other Community Outreach                                    | <input type="checkbox"/> Other _____  | <input type="checkbox"/> Med/Surg  | <input type="checkbox"/> Chaplain or other ecclesiastical worker                     | <input type="checkbox"/> Manpower  | <input type="checkbox"/> Physical, Occupational or Speech Therapist                                      |
| <input type="checkbox"/> Overflow Hospital Shelter                                   | <input type="checkbox"/> Other _____  | <input type="checkbox"/> OB/GYN  | <input type="checkbox"/> Other _____   | <input type="checkbox"/> Security Worker   | <input type="checkbox"/> Pharmacist  |
| <input type="checkbox"/> Patient Screening   |   | <input type="checkbox"/> Operating Room  |  | <input type="checkbox"/> Post Certified  | <input type="checkbox"/> Pharmacy Tech   |
| <input type="checkbox"/> Other _____   |   | <input type="checkbox"/> Pediatrics  |  | <input type="checkbox"/> Public Information or media experience                          | <input type="checkbox"/> Radiology Technician  |
|  |   | <input type="checkbox"/> Other _____   |  | <input type="checkbox"/> Other _____   | <input type="checkbox"/> Respiratory Care Practitioner   |
|  |   |  |  |  | <input type="checkbox"/> Other _____   |



Please check all that apply

**Before you return this application, please check that you have completed the following:**

Completely read, understand and sign the enclosed "WMMRC HIPAA Policy"

Completely read, understand and sign the enclosed "WMMRC Media Release Policy"

Completely read, understand and signed the enclosed "WMMRC Volunteer Risk Policy"

Completely read and understand the enclosed "Volunteer Confidentiality Policy"

Completely read and understand the enclosed "Release of Confidential Information Policy"

Completely read and understand the "Liability Statement"

Completely read and understand the "Authorization to Conduct an Investigational Background Check" in the shaded box below. A satisfactory investigational background check is part of the requirement to become a member of Weber-Morgan's Medical Reserve Corps.

**AUTHORIZATION TO CONDUCT AN INVESTIGATIONAL BACKGROUND CHECK**

I authorize the Weber County Sheriff's Office to conduct an investigation into my background and share that information with the Weber-Morgan Health Department for the purpose of allowing me to enroll in the Weber-Morgan Medical Reserve Corps.

\_\_\_\_\_ Date

Print full name

\_\_\_\_\_

Signature

\_\_\_\_\_ Date of Birth

Utah Driver's License Number

**\* WMHD is committed to protecting your security. Your files are kept confidential**

I have read the above mentioned policies. Furthermore, I understand that I may call the WMMRC Coordinator at 801-399-7100 and have any questions answered prior to signing them. Also, by signing, I agree that I will do my best to meet the training and participation criteria to maintain membership in the Weber-Morgan Medical Reserve Corps.

\_\_\_\_\_ Date

Printed Name of Volunteer

\_\_\_\_\_

Signature of Volunteer