



CENTRAL NEBRASKA MEDICAL RESERVE CORPS

VOLUNTEER APPLICATION

PERSONAL CONTACT INFORMATION (KEPT CONFIDENTIAL)

NAME: Last _____ First _____ **Middle** _____

ADDRESS: Street _____ County _____

City _____ State _____ Zip _____

PHONE: Home _____ Work _____ Mobile _____

E-MAIL: Home _____ Work _____ Pager _____

The following information is required for a background check. Your information will be kept confidential.

Date of Birth _____ **Place of Birth** _____

Drivers License # _____

Gender M F **Social Security #** _____

Ethnic Group: Black White Hispanic American Indian/Alaskan Native Asian/Pacific Islander

Have you ever been convicted of a felony? **Y N** A misdemeanor? (Any traffic violations) **Y N**
If yes, please explain:

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____ Phone _____

Mobile _____ Street _____ City _____ State _____ Zip _____

<u>M.D./D.O.</u>	<u>Nurse Prac.</u>	<u>Pharmacist</u>	<u>CNA</u>
<u>PA</u>	<u>LPN</u>	<u>Pharmacy Tech</u>	<u>Veterinarian</u>
<u>Psychologist</u>	<u>EMT</u>	<u>Lab Tech</u>	<u>Medication Aide II</u>
<u>RN</u>	<u>Paramedic</u>	<u>X-Ray Tech</u>	<u>Phlebotomist</u>
<u>Accountant</u>	<u>Bus Driver</u>	<u>Mechanic</u>	<u>Counselor</u>
<u>Attorney</u>	<u>Secretary</u>	<u>Office Manager</u>	<u>Teacher</u>
<u>Interpreter</u>	<u>Clergy</u>	<u>Mortician</u>	<u>Social Worker</u>
<u>IT</u>	<u>Data Entry</u>	<u>Nutritionist</u>	<u>Ham Operator</u>

Call Sign: _____

*****Only for non-credentialed volunteers*****

The following information is required for a background check. Your information will be kept confidential.

Date of Birth: _____ SSN#: _____
Address: _____ City: _____ State: _____
Previous Address: _____ City: _____ State: _____
Signature: _____

FOREIGN LANGUAGE:

What languages do you **speak** or understand other than English?

_____ Speak _____ Write _____ Read _____

_____ Speak _____ Write _____ Read _____

POSITION OF INTEREST:

LICENSING/CERTIFICATIONS

	License #	State	Expiration
<input type="checkbox"/> Clergy	_____	_____	_____
<input type="checkbox"/> Dentist	_____	_____	_____
<input type="checkbox"/> EMT	_____	_____	_____
<input type="checkbox"/> Epidemiologist	_____	_____	_____
<input type="checkbox"/> Lab Tech	_____	_____	_____
<input type="checkbox"/> Mental Health Practitioner	_____	_____	_____
<input type="checkbox"/> Microbiologist	_____	_____	_____
<input type="checkbox"/> Mortuary Service	_____	_____	_____
<input type="checkbox"/> Nursing RN__ LPN__	_____	_____	_____
<input type="checkbox"/> Nutritionist	_____	_____	_____
<input type="checkbox"/> Paramedic	_____	_____	_____
<input type="checkbox"/> Pharmacist	_____	_____	_____
<input type="checkbox"/> Physician	_____	_____	_____
<input type="checkbox"/> Chiropractor	_____	_____	_____
<input type="checkbox"/> Phlebotomist	_____	_____	_____

- Psychologist _____
- Respiratory Therapist _____
- Social Worker _____
- Substance Abuse Counselor _____
- Veterinarian _____
- X-Ray Tech _____
- Other _____

Area of specialty _____

Are you board certified? Yes ___ No ___
 Do you have prescriptive authority? Yes ___ No ___
 Are you retired and licensable in good standing? Yes ___ No ___

Please attach a copy of your current professional license/certification to this application.

Certification # _____ Expiration _____
 Would you like to be registered for ESAR-VHP? Yes ___ No ___

Please visit www.nevolunteers.com for ESAR-VHP information

AVAILABILITY:

Are you available to respond to emergencies across Nebraska or Iowa? Yes ___ No ___
 Are you available to respond to emergencies in the Mid America Alliance States Region 7 and 8 (Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming)? Yes ___ No ___
 What county areas are you available to respond to? _____
 Availability: Days ___ Evenings ___ Mon ___ Tues ___ Wed ___ Thurs ___ Fri ___ Sat ___ Sun ___

I PREFER TO BE: ___ **INACTIVE** (prepared for service only in an emergency or disaster)
 ___ **ACTIVE** (leader, recruiter, trainer, community health initiatives, etc)

Are you part of any other emergency disaster alert system? Yes ___ No ___

Please indicate counties in which you are willing to serve:

<u>Adams</u>	<u>Franklin</u>	<u>Harlan</u>	<u>Phelps</u>
<u>Blaine</u>	<u>Garfield</u>	<u>Howard</u>	<u>Sherman</u>
<u>Buffalo</u>	<u>Gosper</u>	<u>Kearney</u>	<u>Valley</u>
<u>Clay</u>	<u>Greeley</u>	<u>Loup</u>	<u>Webster</u>
<u>Custer</u>	<u>Hall</u>	<u>Merrick</u>	<u>Wheeler</u>
<u>Dawson</u>	<u>Hamilton</u>	<u>Nuckolls</u>	<u>ALL</u>

Interest in a leadership position within Unit:

Logistics Officer	Safety Officer	Other:
Public Information Officer	Volunteer Relations	Other:

CERTIFICATIONS AND TRAINING

Certifications	Most Recent Date	Certifying Agency
<input type="checkbox"/> CPR	_____	_____
<input type="checkbox"/> First Aid	_____	_____
<input type="checkbox"/> Disaster Training	_____	_____
<input type="checkbox"/> Cert	_____	_____
<input type="checkbox"/> Blood borne Pathogen	_____	_____
<input type="checkbox"/> Incident Command System	_____	_____
<input type="checkbox"/> Epidemiology	_____	_____
<input type="checkbox"/> Bioterrorism	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/>	_____	_____

WORK CONTACT INFORMATION

OCCUPATION: _____ Full time ___ Part time ___ Retired _____

PRESENT EMPLOYER:

Company _____ Position _____ Phone _____ Dates _____

Street _____ City _____ State _____ Zip _____

In the event volunteers are called to respond to an emergency: Please list additional person(s) who may be used to contact you if we are unable to reach you using the information provided above.

Name _____ Phone Number _____

PREVIOUS EMPLOYMENT:

Company _____ Position _____ Dates _____

Company _____ Position _____ Dates _____

VOLUNTEER EXPERIENCE:

Organization _____ Position _____ Dates _____

Organization _____ Position _____ Dates _____

EDUCATION:

School _____ Degree/Specialty _____ Dates _____

School _____ Degree/Specialty _____ Dates _____

PERSONAL REFERENCES:

Please list two people who know your qualifications and/or background experience. Do not list relatives or supervisors. Reference checks will be contacted by phone during regular business hours. Please notify individuals that the Central Nebraska Medical Reserve Corps. We will be contacting them regarding your interest in becoming a volunteer.

Name _____ Relationship to you _____ Address _____
Phone _____ Work Phone _____ Known how long? _____

Name _____ Relationship to you _____ Address _____
Phone _____ Work Phone _____ Known how long? _____

I hereby certify that all the information shown above is accurate and correct and I hereby make application for membership in the Central Nebraska Medical Reserve Corps. I understand that I am applying for a volunteer position and that this is not an application for, or contract of, employment.

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

I do hereby give the Central Nebraska Medical Reserve Corps permission to inquire into my educational background, references, driving record, police records, employment and my volunteer history. I further give permission to the holder of any such records to release same to the Central Nebraska Medical Reserve Corps or its sponsoring agencies. I understand that the Central Nebraska Medical Reserve Corps will only use this information as part of its verification of my volunteer application and periodically for evaluation purposes. I do hereby hold the Central Nebraska Medical Reserve Corp harmless from any liability, whether civil or criminal, that may arise as a result of there release of this information about me. I further hold harmless any individual, agency, business or corporation that provides information or documents to the Central Nebraska Medical Reserve Corp.

A Photocopy of this release form will be valid as an original thereof even though the said photocopy does not contain an original writing of my signature.

Print Name_____ **Signature**_____ **Date**_____