

# PERRY COUNTY MEDICAL RESERVE CORPS VOLUNTEER APPLICATION

**Personal Contact Information**

Full Name ( <i>Last, First Middle</i> )		Alias ( <i>if applicable</i> )	
Mailing Address	City	County	Zip Code
Home Phone	Cell Phone	E-mail Address ( <i>personal</i> )	
Present Employer	Work Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> Retired		
Additional Languages	How did you learn about the Medical Reserve Corps?		
Emergency Contact Name & Relationship	Emergency Contact Phone Number		

**Background Check:** *The following is required for a criminal background check. By submitting this application, you consent to a background check.*

Date of Birth	Place of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Driver's License: (#, State, & Type)	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander	
Have you ever been convicted of a felony or a misdemeanor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:	

**Professional Licensure Information:** Note: *It is not necessary to hold a Professional License to join the Medical Reserve Corps*

Name on License	License Type <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacy <input type="checkbox"/> EMT/Paramedic <input type="checkbox"/> Other _____
License Number	Date of Expiration

**Certifications & Skills**

Please list any relevant certifications or trainings and date of completion: 1. _____ 2. _____ 3. _____
Please list any relevant skills you can bring to the Medical Reserve Corps 1. _____ 2. _____ 3. _____

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

This information is requested by the Perry County Medical Reserve Corps for the purpose of organizing volunteers and staff to respond to area emergencies, disasters or public health emergencies. It will not be utilized or released for any other purpose without your express written permission unless required by law.

Please return applications by email to [mashmore@perryhealth.org](mailto:mashmore@perryhealth.org) or by mail to ATTN: Margaret Ashmore 907 South Main Pinckneyville, IL 62274