

Macomb County Health Department MRC Volunteer Application

Please complete, in full, the following application to become a member of the Macomb County Health Department Medical Reserve Corps. If a section does not apply to you please enter "N/A" and skip to the next section.

Please submit a copy of your drivers license with your application.

I. Personal Contact Information, the following **bold face print** is required for a criminal background investigation.

Last Name: _____ **First Name:** _____ **MI:** _____

Gender: Female Male **Date of Birth** (m/d/year): _____

Ethnicity: African American or Black American Indian or Native Alaskan Asian
 Hispanic or Latino Native Hawaiian or Pacific Islander White or Caucasian

Street Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____, May we contact you via text message? Yes No

Home Fax: _____ Alternate Phone: _____

E-mail Address*: _____

****Email will be the primary way to contact volunteers. If you do not have regular access to a computer, is there a person who does have access to a computer and email address that can be notified of volunteer events and training sessions that can communicate the information to you?***

Yes, please complete the below information No, please contact me by phone/postal mail

A. Contact: _____ Relationship: _____

Email: _____ Phone: _____

B. Contact: _____ Relationship: _____

Email: _____ Phone: _____

II. Work Contact Information

Occupation/Career Path: _____

Full Time Part Time Unemployed Retired Student

Current or Previous Employer: _____ Years of service: _____

Address: _____ Suite: _____ City: _____

County: _____ State: _____ Zip Code: _____

Phone: _____ Extension: _____ Fax: _____

May we contact you at work? Yes No

VII. Other

A. Education (Check highest level completed): High School Associates Bachelors
 Graduate School Medical School Other, please specify: _____

B. Please state your reasons for wanting to volunteer with the Macomb County Health Department MRC:

C. Do you volunteer with other organizations? If **yes**, please list the organizations you volunteer for.
 Yes: _____
 No

D. Have you been involved with emergency preparedness or emergency response? If yes, please briefly describe.
 Yes: _____
 No

E. Do you have family members who depend on you? Yes No
a. If **yes**, have you made plans for their care during an emergency situation? Yes No

F. Are you available to volunteer during an emergency situation*? Yes No

*Choosing "Yes" does not obligate you to volunteer during an emergency but allows us to contact you when volunteer resources are needed.

G. Do you have other obligations that may affect your answer in question 'F'? For example, if you are a member of C.E.R.T., work for a local emergency team, need to care for family, etc.
 Yes, please briefly describe: _____

 No

H. Are you interested in non-emergency volunteer opportunities? Yes No
b. If **yes**, do you have any activities in mind you would like to share?

I. How did you hear about our program?

Macomb County Health Department MRC Consent

I understand that all of the information I've provided on this application will be held confidential within the Macomb County Health Department (MCHD) and is restricted for use by the MCHD Medical Reserve Corps (MCHD-MRC). I give permission to the MCHD-MRC to inquire into my personal and work contact information, licensure, and certifications.

I understand and agree that submitting this application form does not automatically register me as a MCHD-MRC volunteer, and that there may be certain qualifications I must meet, including the acceptance of established volunteer policies and procedures and a criminal background check before I may begin volunteering.

By submitting this form, I agree to a criminal background check and attest that the information I have provided is true and accurate. I am not giving up any of my legal rights by volunteering in the MCHD-MRC and have the opportunity to ask questions and to cease volunteering at any time.

Signature

Print Name

Date

**Once completed return the application and a copy of your drivers license to: Kathleen
McCarthy, via**

Email: Kathleen.mccarthy@macombcountymi.gov

OR

Fax: (586) 307-8259

OR

**Regular postal mail at:
Macomb County Health Department
Attn: EPP; Kathleen McCarthy
43525 Elizabeth St.
Mt. Clemens, MI, 48043**