

R. Joseph Ebel, R.S., M.S., M.B.A.
Health Commissioner



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Licking County Health Department

675 Price Road

Newark, OH 43055

LICKING COUNTY MEDICAL RESERVE CORPS

VOLUNTEER APPLICATION

Please complete the following application. If you need extra space, please feel free to attach additional pages or to continue on the back of the page.

Section 1: Personal Information

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Mobile Phone: _____

E-mail address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Current Occupation: _____

Employer: _____

Employer Address: _____

Work Phone: _____

Section 2: Skills and Education

1st Degree: _____

Institution: _____

Dates Attended: _____

2nd Degree: _____

Institution: _____

Dates Attended: _____

3rd Degree: _____

Institution: _____

Dates Attended: _____

1st License held: _____

Expiration Date: _____

License Number: _____

Pending Action? Y ___ N ___ 2nd

License held: _____

Expiration Date: _____

License Number: _____

Pending Action? Y ___ N ___

Section 3: Relevant Experience

Position	Organization	Dates

Section 4: Volunteering Preferences Circle your availability.

Sundays	Mondays	Tuesdays	Wednesdays	Thursdays	Fridays	Saturdays
Mornings	Mornings	Mornings	Mornings	Mornings	Mornings	Mornings
Afternoons	Afternoons	Afternoons	Afternoons	Afternoons	Afternoons	Afternoons
Nights	Nights	Nights	Nights	Nights	Nights	Nights

Are you interested in volunteering in times of disaster? Y ___ N ___

Are you interested in volunteering with community betterment education and prevention programs throughout the year? Y ___ N ___

Are you available for the necessary disaster response training? Y ___ N ___

Are you interested in obtaining training in addition to the required training, such as disaster response training or opportunities for continuing education credits? Y ___ N ___

Section 6: Verification and Consent

I verify that the above information is accurate to the best of my knowledge. Should any of my information change I will notify the Licking County Health Department of the change. Should the status of my license(s) change in any way, I will notify the Licking County Health Department immediately as to the change or any pending actions against me.

I give the Licking County Health Department permission to inquire into my educational background, licenses, references, police records, and employment and/or volunteer history. I also give permission to the holder of any such information to release it to the Licking County Health Department.

I hold the Licking County Health Department harmless of any liability, criminal or civil, that may arise as a result of the release of any of this information about me. I also hold harmless any individual or organization that provides information to the above-named agency. I understand that the Licking County Health Department will use this information only as a part of the verification process associated with my volunteer application.

Name (please print)

Signature

Date

Return this form to:
Mary Beth Hagstad, R.N., M.S.N., C.N.S., Nursing Manager & Medical Reserve Corps Coordinator
Licking County Health Department
675 Price Road, Newark, Ohio 43055
mhagstad@lickingcohealth.org
Phone: 740-349-6685
Fax: 740-349-6510