CAPE MAY COUNTY MEDICAL RESERVE CORPS APPLICATION

I. Personal Contact Information

Last Name____________________First Name_______________MI__ Dr. Mr.Mrs.MS

Home Address Street___________________Apt._____Town_____________________

County_________________State_________________ Zip__________

Home Phone (___)__________Cell Phone (___)__________Fax (____)_____________

Email Address_____________________________Personal Beeper(_____)___________

II. Work Contact Information

Occupation_____________________F/t___P/T___Per Diem___Retired___Student___

Employer______________________Address___________________________________

General Phone Number (_____)_______________Ext._________Fax(____)__________

Please list a contact person if we are unable to reach you:

Contact_____________________Phone Number(_____)________Relationship________

III. Personal Information

Sex M F Date of Birth___/___/___ Social Security_____-_____-_____

Education High School____Diploma____College____Graduate School____Other_____

Do you have any health related issues that would impact your ability to volunteer? Yes__No__

If yes, please list or speak personally to the MRC Coordinator.

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IV. Licenses

A. Are you certified or licensed healthcare professional? Yes____No__

*If " **YES**" mark all applicable degrees or certifications:* licensed in NJ

		licensed in NJ
1. MD/DO	Y __ N __	Y __ N__
2. DVM/VMD	Y __ N __	Y __ N__
3. RN	Y __ N __	Y __ N__
4. LPN	Y __ N __	Y __ N__
5. EMT/Paramedic	Y __ N __	Y __ N__
6. PA/NP	Y __ N __	Y __ N__
7. Pharmacist	Y __ N __	Y __ N__
8. Pharmacy Tech	Y __ N __	Y __ N__
9. Psychiatrist/Psychologist	Y __ N __	Y __ N__
10. Counselor	Y __ N __	Y __ N__
11. Social Worker	Y __ N __	Y __ N__
12. Dentist	Y __ N __	Y __ N__
13. Other___________________	Y __ N __	Y __ N__

License Number__________________ Exp. Date___________________

V. Certification & Training

A. **Certification**	Exp. Date
1. CPR ___	________
2. ACLS ____	________
3. PALS ____	________
4. TNCC ____	________
5. First Aid ____	________
6. EMT/Rescue ____	________
7. CERT ____	________
8. ICS ____	________
9. HazMat ____	________
10. Other ____	________

B. Training:

1. Orientation to MRC: on-line___ classroom___
2. Orientation to Public Health: on-line___ classroom____
3. Distributing Supplies from the National Strategic Stockpile: on-line___ class room___
4. Practicing Cross Cultural Communication: on-line___ classroom____
5. Psychological Aspects of Bioterrorism & Disaster Response: on-line___ classroom___
6. Health Literacy & Public Health: on-line____
7. Blood borne Pathogens: on-line___ classroom____
8. Red Cross Shelter Training: _____

VI. Office & Administrative Skills

A. Computer Skills

1. I routinely use a computer and can use a desktop or laptop with out difficulty. ___
2. I have limited computer skills.____
3. I cannot use a computer,____

B. Access

1. I have access to a computer at home.__
2. I have access to a computer at work.__
3. I have email at home.__
4. I have email at work.__

C. Supervision

1. Have you ever supervised staff or volunteers? Y__N__
   If yes, in what capacity____

D. Do you have a valid drivers license? Y__N__

1. Do you have a commercial driver's license (CDL)Y__N__
2. Do you have access to a private vehicle that you could use in case of emergency?Y__N__

VII. Language Skills

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

Language Spoken	Fluency	Able to read	Able to write
_______________	excellent/good/fair	Y__N__	Y__N__
_______________	excellent/good/fair	Y__N__	Y__N__

VIII. Clinical Skills

A. Are you experienced in giving injections? Y__N__ Adults___ Children___

B. Are you able to draw blood? Y__N__ Adults___ Children___

C. Are you able to start IVs? Y__N__ Adults___Children___

D. Have you experience with triage? Y__N__

E. Have experience with hotlines? Y__N__

F. Have you experience with contact tracing? Y__N__

G. Have you ever received training on how to administer smallpox vaccine? Y__N__

IX. Vaccine History

A. Have you ever been vaccinated against any of the following disease pathogens? Please list year of vaccination.

1. Anthrax Y__N__ Year_____
2, Influenza Y__N__ Year_____
3. Hepatitis A Y__N__ Year_____
4. Hepatitis B Y__N__ Year_____
5. Meningitis Y__N__ Year_____
6. Smallpox Y__N__ Year_____
7. Tetanus Y__N__ Year_____
8. Other Y__N__ Year_____

X. Miscellaneous

Please list other skills you may possess that would be valuable during a disease outbreak or emergency situation.

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Do you have specific training or refresher needs?

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Are you willing to work in Cape May County? Y__N__

Are you willing to work anywhere in New Jersey? Y__N__

May we share you information with the state of New Jersey Medical Reserve Database?

Y__N__

Cape May County Medical Reserve Corps Consent

I understand that all of the information I've provided on this application will be held confidential within Cape May County Department of Health and is restricted for use by the Cape May County Medical Reserve Corps. I give my permission to the Cape May Department of Health to inquire into my personal and work contact information, licensure, certification, vaccine, and personal health information provided. I am not giving up any of my legal rights by volunteering in the Cape May County Medical Reserve Corps and have the opportunity to ask questions and to cease volunteering at any time.

______________________________	______________________________
Signature	Date

____

Print Name

Please return application to Joan Rowland via fax (609) 463-6580 or regular mail at 4 Moore Road, Cape May Court House, NJ 08210