



The Cape Cod Medical Reserve Corp is accepting applications for both medical and non-medical volunteers. Please complete the application and CORI forms below. If you have questions, please contact:

Lynda C. Costa, Director Cape Cod MRC
Barnstable County Dept. of Health & Environment
P.O. Box 427, 3195 Main Street
Barnstable, MA 02630
lcosta@barnstablecounty.org

What is the Medical Reserve Corp?

- The MRC was founded after President Bush's 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. It is a partner program with [Citizen Corps](#), a national network of volunteers dedicated to ensuring hometown security.
- MRC units are community-based and function as a way to locally organize and utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year. MRC volunteers supplement existing emergency and public health resources.
- MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.
- MRC units are provided specific areas to target that strengthen the public health infrastructure of their communities by the U.S. Surgeon General. These are outlined priorities for the health of individuals, and

the nation as a whole, which also serve as a guide to the MRC. The overarching goal is to improve health literacy, and in support of this, he wants us to work towards increasing disease prevention, eliminating health disparities, and improving public health preparedness.

- MRC volunteers can choose to support communities in need nationwide. When the southeast was battered by hurricanes in 2004, MRC volunteers in the affected areas and beyond helped communities by filling in at local hospitals, assisting their neighbors at local shelters, and providing first aid to those injured by the storms. During this 2-month period, more than 30 MRC units worked as part of the relief efforts, including those whose volunteers were called in from across the country to assist the American Red Cross (ARC) and the Federal Emergency Management Agency (FEMA).

During the 2005 Hurricane Season, MRC members provided support for ARC health services, mental health and shelter operations. MRC members also supported the HHS response and recovery efforts by staffing special needs shelters, Community Health Centers and health clinics, and assisting health assessment teams in the Gulf Coast region. More than 1,500 MRC members were willing to deploy outside their local jurisdiction on optional missions to the disaster-affected areas with their state agencies, the ARC, and HHS. Of these, almost 200 volunteers from 25 MRC units were activated by HHS, and more than 400 volunteers from more than 80 local MRC units were activated to support ARC disaster operations in Gulf Coast areas.



Cape Cod Medical Reserve Corps Volunteer Application

(Medical)

Personal Contact Information

Dr. Mrs. Mr. Ms.

Last Name _____ First Name _____ MI _____ (Circle one above)

Home Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone # (____) _____ Cell Phone # (____) _____ Work Phone # (____) _____

E-mail Address _____ Personal Pager # (____) _____

Business (Mailing) Address: _____

City _____ State _____ Zip Code _____

In case an emergency happens *to me* please contact:

Name: _____ Relationship: _____

Daytime phone number: _____ Evening phone number: _____

Although the focus of our unit is on local emergencies, would you like us to call you in case of a statewide or national emergency (such as Hurricane Katrina relief efforts in 2005)? Please circle any that apply:

National Statewide Region My town only

Would you be interested in leadership positions within the MRC? YES ____ NO ____

Please check one of the following volunteer opportunities that best describe how you would like to participate in the MRC Program.

_____ MRC Emergency Team Member (Activated only in case of local emergency, notified of trainings and drills)

_____ MRC General Team Member (Activated for local emergencies, called to help with special projects and events, notified of trainings and drills.)

_____ MRC General Team Leader Role (Activated for local emergencies, called to help with special projects and events, notified of trainings and drills, administrative and clerical duties.)

Would you also be interested in being a member of the National MRC Auxiliary? This group can be activated as part of a local team to respond to State and National

emergencies. (Extra training and credentialing required by the Surgeon General's Office) **Yes No**

For applicants interested in volunteering for non-emergency assignments, what hours do you prefer?

_____ Weekday mornings _____ Weekday afternoons _____ Weekday evenings
_____ Weekend mornings _____ Weekend afternoons _____ Weekend evenings

Are you part of any other organization? (e.g. American Red Cross, CERT, a local hospital, etc.) If yes, please list below. **Yes No**

Who would you respond to first if on multiple lists?

If volunteers are needed for response to an emergency during the hours when you'd be working, is it ok to contact you at your place of employment? **Yes No**

If yes please provide the following information:

Occupation (check) : Full Time Part Time Retired Student

Employer Address _____

General Phone Number (____) _____ Your extension _____ Fax #(____) _____

Education (check highest level): High School College Graduate School Other

School Name: _____ Location: _____

Type of Degree: _____ Major/Specialization: _____ Year Graduated: _____

License (Professionals with a current license or certification in any health or mental health field)

Circle all applicable: *License/Certification #* *Expiration Date*

1. M.D./ D.O. _____

2. D.V.M./ V.M.D. _____

3. D.D.S./D.M.D. _____

4. D.C. _____

5. R.N. _____

6. L.P.N. _____

7. EMT/ Paramedic _____

8. P.A/ N.P. _____

9. Pharmacist _____

10. Psychiatrist/Psychologist _____

11. Other Mental Health Practitioner _____

12. Social Work LSCSW LMSW LBSW _____

13. Other health related degrees or licenses _____

14. Do you have prescriptive authority? **Yes** **No**

Have you ever had your professional license suspended or revoked? **Yes** **No**
(Please attach letter of explanation)

Certifications & Training (Check any that apply)

| Certifications | Most Recent Date | Certifying Agency |
|---|-------------------------|--------------------------|
| <input type="checkbox"/> CPR _____ | | |
| - | | |
| <input type="checkbox"/> Aid _____ | | First |
| <input type="checkbox"/> Training _____ | | Disaster |
| <input type="checkbox"/> CERT _____ | | |
| - | | |
| <input type="checkbox"/> Blood borne Pathogens & Standard Precautions _____ | | |
| <input type="checkbox"/> Training _____ | Military | Medical |

Training (Check/circle any that you have attended)

- | | |
|--|--|
| <input type="checkbox"/> Incident Command System 100/200 other | <input type="checkbox"/> Other Training (list below) |
| <input type="checkbox"/> NIMS-700 | _____ |
| <input type="checkbox"/> Epidemiology | _____ |

- Bioterrorism _____
- Terrorism & emergency response to terrorism _____

Languages

What languages do you **spea**k or understand other than English? Please list and indicate level of fluency: *(Include sign language)*

| | | |
|-------------------------|--------------------------------------|-----------------|
| Languages spoken: _____ | level of fluency <i>(circle one)</i> | Read and write? |
| _____ | Excellent Fair Poor | Yes No |
| _____ | Excellent Fair Poor | Yes No |

Volunteer Interests

Please check any fields of interest listed below:

Clinical Work _____ Deliveries _____ Fundraising _____ Administration _____
 Health Education _____ Newsletter Production _____ Phone Bank _____
 Volunteer Coordination _____

Personal Health

Do you have any personal health issues that would impact your ability to volunteer? **Yes No**
 (For example allergies, medication issues, disabilities, special needs, or being treated for a medical condition)

If yes, please either list here or speak personally with the MRC Coordinator.

References: Please list three references who are familiar with your qualifications/experience. Do not list relatives.

| | |
|---------------|--------------------|
| Name _____ | Phone Number _____ |
| Address _____ | |
| Name _____ | Phone Number _____ |
| Address _____ | |
| Name _____ | Phone Number _____ |
| Address _____ | |

All of the information that I have supplied is correct to the best of my knowledge. I do hereby give my local Medical Reserve Corps (MRC) permission to make inquiries concerning my educational background, references, driving record, present and previous employment, licenses, certifications and police record. I further give permission to the holder of any such records to release the same to the MRC. I hold the MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of the information about me. I also hold harmless any individual, agency, business or corporation that provides information to the MRC. I recognize that I should investigate my personal and business liability coverage as pertains to my volunteer work for the MRC. I recognize that prior to being accepted as a MRC volunteer, I may be required to provide additional documentation as proof of certain certifications (CPR, First Responder, CDL, etc.)

I understand that I am a volunteer and will not be paid for any of my services.

I give my permission for the MRC to release personal information to local, state and federal emergency management agencies and other Health and Human Service agencies as needed.

Be sure this box is checked if you accept these terms, and sign your name below.

_____ Date: _____

**Please mail application to:
Lynda C. Costa, Director Cape Cod MRC
Barnstable County Dept. of Health & Environment
P.O. Box 427, 3195 Main Street
Barnstable, MA 02630
Or
Fax to: (508) 362-2603**



Cape Cod Medical Reserve Corps Volunteer Application

(Non-medical)

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Dr. Mrs. Mr. Ms.

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In case an emergency happens *to me* please contact:

Name: _____ Relationship: _____

Daytime phone number: _____ Evening phone number: _____

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 Are you part of any other organization? (e.g. American Red Cross, CERT, a local hospital, etc.) If yes, please list below. **Yes No**

Who would you respond to first if on multiple lists?

Education (check highest level): High School College Graduate School

Other

School Name: _____ Location: _____

Type of Degree: _____ Major/Specialization: _____ Year Graduated: _____

Certifications & Training (Check any that apply)

| Certifications | Most Recent Date | Certifying Agency |
|---|------------------|--|
| <input type="checkbox"/> CPR _____ | | |
| - | | |
| <input type="checkbox"/> Aid _____ | | First |
| <input type="checkbox"/> Training _____ | | Disaster |
| <input type="checkbox"/> CERT _____ | | |
| - | | |
| <input type="checkbox"/> Blood borne Pathogens & Standard Precautions _____ | | |
| <input type="checkbox"/> Training _____ | Military | Medical |
| <input type="checkbox"/> Incident Command System 100/200 other | | <input type="checkbox"/> Other Training (list below) |
| <input type="checkbox"/> NIMS-700 | | _____ |
| <input type="checkbox"/> Epidemiology | | _____ |
| <input type="checkbox"/> Bioterrorism | | _____ |
| <input type="checkbox"/> Terrorism & emergency response to terrorism | | _____ |

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| | Excellent Fair Poor | Yes No |
| _____ | Excellent Fair Poor | Yes No |

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| Address _____ | |
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| Address _____ | |

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Or
Fax to: (508) 362-2603**

Requested by: _____
Signature of CORI authorized employee

*The CHSB Identify Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.