

VOLUNTEER APPLICATION

Please print or type

Last Name	First Name	M.I.	Sex
Street Address (Mailing)			
City		State	Zip
Home Phone	Work Phone	Cell Phone	
Email		Employer	

Type: Healthcare Professional: <i>(i.e. MD, RN, PA, NP, Pharmacist, EMT, Paramedic, Respiratory Therapist, Mental Health, etc)</i>	Type: Non Healthcare <i>(i.e. Administration, Clerical, Security, etc)</i>	Requested means of communication: <input type="checkbox"/> Mail to above address <input type="checkbox"/> Email to above <input type="checkbox"/> Other (specify) _____
For All Healthcare Professionals: Please indicate License Number or Certificate/Registration Number #		Other Languages spoken State License Held Degree(s) Obtained
Valid: Y / N Expires:		

Level of Participation Desired: I prefer to be:

ACTIVE Receives notifications of ALL training opportunities, training drills & exercises, emergency events, as well as non-emergency volunteer opportunities

LIMITED Receives only notification of training drills and exercises and all emergency events

EMERGENCY ONLY Receives notification of only major emergency events

NOTE: All volunteers are required to take the orientation training and ICS 100 & 700 prior to participation in training drills and exercises. In addition, CPR & First Aid must be current in order to participate in actual emergency responses and/or activations.

Do you have any current or pending actions against your professional license? Yes No

I understand that a Criminal Background Check is required of all volunteers. Initials _____

- Have you ever been convicted of a misdemeanor? Yes No
- Have you ever been convicted of a felony? Yes No

Birth date ____/____/____ Other Names Used _____

Additional comments you would like to add, please use this section.

Signature	Date
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Privacy Act Statement

This information is requested by the Stanislaus 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 email to: msherwood@schsa.org or
 Fax: 209.558.8854 or
 Mail to: Stanislaus County Medical Reserve Corps
 Attn: Mary Sherwood, Coordinator
 830 Scenic Drive, Modesto, CA 95350

VOLUNTEER PRIVACY, CONFIDENTIALITY AND SECURITY STATEMENT

I understand that I have the responsibility to protect the privacy and confidentiality of all individual identifiable health information relative to patients and their families who receive care by the Stanislaus County Medical Reserve Corps (SCMRC). I understand that any discussions concerning patients should be to assist in the care of that patient. If it is necessary to discuss patient information, I will take reasonable efforts to do so in a private environment to ensure that conversations will not be over-heard by others who are not involved in the patient's care. I am not to discuss any patient information outside the worksite or with individuals not directly associated with the care of the patient.

I also understand that it is my responsibility to safeguard all patient health information. I am not to share electronic passwords, keys or codes to access or allow others to access patient health information.

I understand that I cannot reveal the name of patients seeking services at any location or facility where I am a representative of the SCMRC for any reason, even if they are known to me. Additionally, I am not to reveal any information related to any patients including, but not limited to, reason for visit, test results, diagnoses, procedures, operations, or any other information obtained as a result of a said visit without a written authorization from the patient/legal representative and approval from the Manager/designee.

I understand that an invasion of privacy, breach of confidentiality and/or lack of protection of patient health information will constitute grounds for disciplinary action including termination from the SCMRC.

I also understand that unauthorized disclosures of protected health information which results in economic loss or personal injury to the patient may subject me and/or the SCMRC and its sponsoring agency, Health Services Agency (HSA), to civil action for said violation.

Date _____

Signature _____

Name _____

(Please print)

PHOTOGRAPH AND MEDIA CONSENT

The Stanislaus County Medical Reserve Corps (SCMRC) may take photos, videos or otherwise document volunteers in action during meetings, trainings, exercises or other activities in which I have volunteered. Such photographs may be used on or in SCMRC, Health Services Agency (HSA), or partnering agency's, websites, newsletters and other publications without compensation to me (a volunteer), my family, representatives, or heirs.

I have read the above and fully understand that this is a release and I give SCMRC, HSA and/or their representative **my permission** to use my photo as stated above.

Date _____

Signature _____

Name _____
(Please print)



CONSENT TO REGISTRATION
DISASTER HEALTHCARE VOLUNTEERS WEBSITE

All Stanislaus County Medical Reserve Corps (MRC) volunteers will be registered on the CA Disaster Healthcare Volunteers website. This site is utilized by the MRC coordinator to communicate with its volunteers and is the primary notification system in a disaster or public health crisis where volunteers may need to be contacted. This system is also used to disseminate information regarding training opportunities, exercises and important alerts.

Volunteers that have not previously registered on this site will be entered into the system using the quick registration method. You will then be notified that you have been entered into the system and must complete the registration process. If you do not have access to a computer, or are in need of assistance in completing your registration, contact the MRC coordinator at 558-7549. The coordinator can complete the registration for you over the phone.

I understand that in order to receive communication from the Stanislaus County Medical Reserve Corps, I will need to be registered on the California Disaster Healthcare Volunteers website. I give my consent to be entered into this system and I have received the Terms of Service and Privacy Policy for the Disaster Healthcare Volunteers of California notification system.

Date _____

Signature _____

Name _____

(Please print)