



# Schoharie County Medical Reserve Corps Volunteer Registration

PLEASE PRINT CLEARLY

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Email: \_\_\_\_\_ Ph: HM (\_\_\_\_) \_\_\_\_\_

WK (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_ PGR (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone (day) : \_\_\_\_\_ ( eve): \_\_\_\_\_

**Skills & Training: Please check any of the following in which you have expertise & training. (Circle yes or no where appropriate):**

- |   |                            |                       |
|---|----------------------------|-----------------------|
| ____ First Aid (current card? yes/no)     | ____ CPR (Current? Yes/no) | ____ Triage/Trauma    |
| ____ Firefighting                         | ____ Search & Rescue       | ____ Law Enforcement  |
| ____ Shelter Management                   | ____ Emergency Management  | ____ Food Preparation |
| ____ CB radio/Ham Radio                   | ____ Pastoral care         | ____ Animal handling  |
| ____ EMT/Paramedic (current card? yes/no) | ____ Behavioral Health     | ____ Other: _____     |

**Licenses** (Current license or certification in any health or mental health field)

List all Professional Licenses      State Issued & Number      Expiration Date

\_\_\_\_\_  
\_\_\_\_\_

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

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

Languages spoken:	Level of fluency (circle one)	Read	Write
_____	Excellent    Fair    Poor	Yes    No	Yes    No

**List any other special skills you can offer.**

\_\_\_\_\_  
\_\_\_\_\_

**Volunteer and Work Experience** (Beginning with the most recent):

Position      Organization      Dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Availability (days and hours)** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Have you ever been convicted of a felony?**  Yes  No If yes, please specify:

\_\_\_\_\_  
**Do you have any personal health issues that would impact your ability to volunteer such as heart conditions, physical impairments, asthma, allergies etc?** \_\_\_yes \_\_\_ No If yes please specify: \_\_\_\_\_

**Are you part of an emergency/disaster plan with any other organization? (Such as the American Red Cross, hospital, etc.) ?**  Yes  No If yes, please list:

\_\_\_\_\_  
**Special interests/training topics:** \_\_\_\_\_

<b>I hereby certify that all statements contained on this registration are true to the best of my knowledge.</b>	
_____ <b>Signature</b>	_____ <b>Date</b>

**Please return your registration to: Schoharie County MRC  
C/O Schoharie County Health Department  
PO Box 667  
Schoharie, NY 12157-0667**