



Contra Costa County Medical Reserve Corps

VOLUNTEER APPLICATION

Please Print or Type

Name	Sex	Height	Weight	Eye Color
Street Address (Mailing)				
City		State	Zip	
Home Phone	Work Phone		Cell Phone	
Drivers License #			Date of Birth	
Email				
Languages Spoken:				
Medical Professional (check one)	Emergency Contact Information:			
Doctor	Name:			
Nurse	Address:			
Dentist	Home #:			
Pharmacist	Cell#:			
Psychiatrist				
EMT				
Other _____				
License or Certificate/Registration Number		State License Held	Expiration Date	
Level of Participation Desired (check one)				
ACTIVE		Receive notifications of ALL training opportunities, drills & exercises, emergency events, as well as non-emergency volunteer opportunities.		
LIMITED		Receive only notifications of training drills, exercises, and all emergency events.		
DHV ONLY		Receive notification only in an emergency.		
A Criminal Background Check is required of all volunteers.				
I do hereby give the Contra Costa County Medical Reserve Corps permission to release personal information to local, state and federal emergency management agencies and other Health and Human Services agencies as needed.				
Signature _____			Date ____/____/____	
<i>The above information was verified by viewing a US government issued identification</i>				
Signature of CCC MRC Coordinator _____			Date ____/____/____	

Privacy Act Statement

This information is requested by the Contra Costa County Medical Reserve Corps and is for the purpose of organizing volunteers and staff to respond to public health emergencies. It will not be utilized or released for any other purpose without your express written permission unless required by law and all information will be kept in a secure manner.