The Orange County Medical Reserve Corps Volunteer Application Form

Prerequisites for membership:

1. US Citizenship or Legal Permanent Residency.
2. 16 years or older. Anyone 16 or 17 require signature of parent or guardian.
3. Valid Driver's license (all 18 yrs or over)

Contact Information:

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Membership Type applying for: Medical Non-Medical Junior (16/17 yrs)
(circle answer) Mentor Program

Name: ____

Home Address: ____

City: ______________________________ State: __________ Zip: _____________

Mailing Address: ____

Daytime Phone: (____) _________________Fax: (___) ______________________

Evening Phone: (____) ______________Cell Phone: (____)__________________

Emergency Contact Name: _______________ Number: (____)_________________

Email: ____________________________

Date of Birth: _______ Driver's License Number: __________State:___ Exp. Date: ____

Junior Members: Name of high school: ___________________________________
Career interests: ______________________________________

Professional Licenses Information:

Professional Title: ____________________Any Specialties: ______________________

Professional Licenses Numbers: ____

Professional Affiliations (Hospitals, Clinics, Private Practice, etc.):
____

Present Employer: ____

Position Held: _______________________ Address: ____________________________

Do you Carry Malpractice Insurance? Yes No
(circle answer)

Do you have any Special Needs or Physical Limitations that you would like us to know?
Yes No (If Yes, please explain in the remarks section)

Have you ever been convicted of a Crime? Yes No

Skills/ Experience:

Languages Spoken/Written:____

(Circle all that apply)

ICS Command or General staff EOC Operations Supervisory
Warehouse/stock Site Planning Public Information/Press Relations Social Media
Photography Training/Educator Fire Fighter Data Entry Dietitian
Safety Officer Call Taker Records Management IT networking/Software
Finance Host/Hostess Event Planning/Management

Hobbies: (Print)

____
____
____

Anything else you think we can use: (Print)

____
____
____

Signature: ______________________________ **Date**:_______________

I certify by this signature that all the information contained in this application and any accompanying material is true.

Parent or Guardian Signature: ____

Phone Number: ________________ email: ___________________________________

Complete and return this form to:
The Medical Reserve Coordinator
124 Main St, Goshen NY 10924
Or
mrccoordinator@orangecountygov.com

Application Review

Applicants Name: _______________________________

Date review started: _____________________

Staff level: Licensed Medical: _________ Non-Licensed Medical ________
(send to Risk Management or verify via state Ed.)

Verification of professional license(s):

Verifier: _________________ Date: __________
Type License found: _____________Expiration Date: ______________
Were any recent disciplinary actions against this license found? Yes No
If Yes, explain: ____
____

Reviewers:

MRC Coordinator: _____________________________ Date: _____________

Deputy Commissioner of Health: __________________ Date: ____________

Commissioner of Health: ________________________ Date: _____________

Accepted: Yes_______ Date: _______
No _______ Reason: __________________________________

Applicant Notified of results by: ___________________ Date: ____________
Phone ___ Email ___ Regular mail ___