



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: _____

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 EMT Data Entry
- Dietitian Safety Officer/Planner Call Taker Records Management
- Advertising 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
jwood@orangecountygov.com

Application Review

MRC Coordinator: John M Wood Sr.
845-360-6628 or jwood@orangecountygov.com

Applicants Name: _____

Date review started: _____

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

OC Risk Management 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: _____

Director of Patient Services: _____ Date: _____

Commissioner of Health: _____ Date: _____

Accepted: Yes _____ Date: _____
No _____ Reason: _____

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