



Please return to:

Thurston County Public Health and Social Services  
 ATTN: Medical Reserve Corps  
 412 Lilly Rd. NE  
 Olympia, WA 98506-5132  
 Phone: (360) 867-2500

# Volunteer Application

Contact Information																	
Name: Last:		First:			MI:		Suffix:		Nickname:								
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. Other		How did you hear about the Medical Reserve Corps: <input type="checkbox"/> Radio <input type="checkbox"/> Mailing <input type="checkbox"/> Website <input type="checkbox"/> Presentation Other															
Gender: Male Female		Are you currently an employee of Thurston County? Yes No			Are you a US Citizen? Yes No												
Address:					Apt:												
Address 2:			City:		State:		Zip:										
Phone Home: ( ) -			Work: ( ) -			ext.											
Cell: ( ) -			Text: ( ) -			Pager: ( ) -											
E-Mail 1:			E-Mail 2:														
What interests you in the Medical Reserve Corps?																	
Preferred Contact Method(s)		<input type="checkbox"/> Work		<input type="checkbox"/> Home		<input type="checkbox"/> Cell		<input type="checkbox"/> Text		<input type="checkbox"/> Pager		<input type="checkbox"/> E-Mail 1		<input type="checkbox"/> E-Mail 2			
Best time to contact:		<input type="checkbox"/> Days		<input type="checkbox"/> Evening													
Do you possess a valid WA state driver's license?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Exp. Date:		Class:		State:		License #:							
Employment Information																	
Place of Employment:					Position:												
Work Address:			City:		State:		Zip:										
Primary Responsibilities:																	
Emergency Contact – Will be notified in case of an emergency																	
Name Last:			First Name:			Relationship:											
Address:			City:		State:		Zip:										
Phone Number: ( ) -			Alternate phone Number: ( ) -														
Additional Information																	
Language:		Fluent? <input type="checkbox"/>		Speak? <input type="checkbox"/>		Read? <input type="checkbox"/>		Write? <input type="checkbox"/>									
Language:		Fluent? <input type="checkbox"/>		Speak? <input type="checkbox"/>		Read? <input type="checkbox"/>		Write? <input type="checkbox"/>									
Availability																	
Are you committed to any other organization in the event of a public health emergency, by virtue of employment or volunteerism?								<input type="checkbox"/> Yes <input type="checkbox"/> No									
What organization?																	
For how long are you willing to deploy		<input type="checkbox"/> Up to 1 day		<input type="checkbox"/> Up to 3 Days		<input type="checkbox"/> Up to 1 week		<input type="checkbox"/> 2 Weeks or more		<input type="checkbox"/> Not Sure							
In the event of an emergency activation which order should we use to contact you? (1, 2, 3 etc...)		<input type="checkbox"/> Work		<input type="checkbox"/> Home		<input type="checkbox"/> Cell		<input type="checkbox"/> Text		<input type="checkbox"/> Pager		<input type="checkbox"/> E-Mail 1		<input type="checkbox"/> E-Mail 2		<input type="checkbox"/> Not Sure	
Where are you willing to volunteer (check all that apply)		Thurston County		Western Washington		Statewide		Nationally		Comments:							
Experience: Do you have any of the following skills?																	
<input type="checkbox"/> Clerical Work		<input type="checkbox"/> Disease investigation		<input type="checkbox"/> Pastoral Care Professional		<input type="checkbox"/> Interviewing											
<input type="checkbox"/> Computer Skills		<input type="checkbox"/> Elderly/Disabled assistance		<input type="checkbox"/> Public Speaking		<input type="checkbox"/> Inventory Supplies											
<input type="checkbox"/> Counseling Skills		<input type="checkbox"/> Retired Healthcare Professional		<input type="checkbox"/> Management/Supervision		<input type="checkbox"/> Education/Teaching											
<input type="checkbox"/> Data Entry		<input type="checkbox"/> Office Management		<input type="checkbox"/> Security/Law Enforcement													
<input type="checkbox"/> Customer Service		<input type="checkbox"/> Phones/Switchboard		<input type="checkbox"/> Amateur Radio Operator													

<b>Training/Continuing Education</b>		
<b>Have you completed any training or continuing education in the following areas?</b>		
<input type="checkbox"/> Advanced Cardiac Life Support (ACLS)	<input type="checkbox"/> Citizen Emergency Response Team	<input type="checkbox"/> Isolation and Quarantine
<input type="checkbox"/> Advanced Trauma Life Support (ATLS)	<input type="checkbox"/> CPR/AED	<input type="checkbox"/> Mental Health Training for Disasters
<input type="checkbox"/> Basic Cardiac Life Support (BLS)	<input type="checkbox"/> CBRNE Training	<input type="checkbox"/> Triage
<input type="checkbox"/> Basic Disaster Life Support (BDLS)	<input type="checkbox"/> Exercise Design and Evaluation	<input type="checkbox"/> Vaccination Administration
<input type="checkbox"/> Blood borne Pathogens	<input type="checkbox"/> Incident Command Training (ICS)	<input type="checkbox"/> First Aid
<b>Other Experience</b>		
<b>Please feel free to add any other experience or training including volunteer, work or life experience.</b>		
<b>References</b>		
<b>Please list three professional or personal references from people other than family members.</b>		
Name:	Phone: (    )    -    ext.	How you know this person:
Name:	Phone: (    )    -    ext.	How you know this person:
Name:	Phone: (    )    -    ext.	How you know this person:
<b>Education</b>		
School:	City/State:	Degree(s):
School:	City/State:	Degree(s):
School:	City/State:	Degree(s):
<b>For Health Professionals Only</b>		
<b>Professional Licensure, Certification, Specialties, Experience</b>		
Name on License/Certification:		State:
License/Certification Number:		Exp. Date:
Specialty within the above professional licensure/certification that you possess:		
Sub specialty with the above professional licensure/certification that you possess:		
Name on License/Certification:		State:
License/Certification Number:		Exp. Date:
Specialty within the above professional licensure/certification that you possess:		
Sub specialty with the above professional licensure/certification that you possess:		
<b>Release of Information</b>		
<p><i>I verify that the information provided in the Thurston County Medical Reserve Corps application is accurate to the best of my knowledge.</i></p> <p><i>I give permission for Thurston County to inquire into my educational background, references, licenses, driving records, police reports, employment or volunteer history.</i></p> <p><i>I also give permission to the holder of any such information to release it to Thurston County.</i></p> <p><i>I hold Thurston County harmless of any liability, criminal or civil, that may arise as a result of the release of this information. I also hold harmless any individual or organization that provides information to the above-named agency. I understand that Thurston County will use this information only as part of its verification of my volunteer application.</i></p>		

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_