

DeKalb County Board of Health Emergency Preparedness Volunteer Information Form



Please answer all questions. Please print all written information clearly.

Personal Contact Information

Title (check one): Dr. Mrs. Mr. Ms. _____ Today's date: _____

Last Name: _____ First Name: _____ MI: _____

Maiden name or other names used: _____

How did you hear about our MRC? _____

Home Address: Street: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Home Fax #: _____

Email Address (es): _____

Other contact number(s): _____

****Please indicate which number is the BEST number to contact you for activation:** _____

Emergency Contact Information: Please provide a contact name that can be reached if you are injured, etc.

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Additional Emergency Contact Information: _____

In the event that you are activated to respond to an emergency: Please list additional person(s) who may be used to contact you if we are unable to reach you using the information provided.

Contact: _____ Phone #: _____

Relationship: _____

Additional phone #: _____

Additional Contact Information: _____

Work Contact Information

Occupation: _____ (check one) Full Time Part Time Retired Student

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____

General Phone #: _____ Your Extension: _____ Fax #: _____

Education

Education (check highest): High School College Graduate School Other: _____

Major/Specialization: _____

Licensure

(Professionals with a current license or certification in any health or mental health field)

Please check all that apply:

<input type="checkbox"/> Physician: Area(s) of specialty: _____	•Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nurse: <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> Nurse Practitioner	•Area(s) of Specialty: _____
<input type="checkbox"/> Student •Area(s) of Study: _____	<input type="checkbox"/> Dentist
<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> Veterinarian
<input type="checkbox"/> Paramedic	<input type="checkbox"/> Vet Tech
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Environmental Health Specialist
<input type="checkbox"/> Mental Health Practitioner	<input type="checkbox"/> Physical Therapist
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Respiratory Therapist
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Police/Law Enforcement
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Firefighter
<input type="checkbox"/> Nurse Assistant	<input type="checkbox"/> Military background •Specialty:
<input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Health Education
<input type="checkbox"/> Phlebotomist	<input type="checkbox"/> Health Technician
<input type="checkbox"/> Other: (please describe): _____	

If your profession requires a license, please indicate whether you have a current, active license:

Current, active license

Inactive license

Do you have Rx authority? Yes No

Do you have hospital privileges? Yes No

If yes, please indicate where? _____

Certifications and Training

Check all that apply:

Certifications:

Most Recent Date

Certifying Agency

CPR

First Aid

Disaster Training

CERT

Military Medical Training

Other Certifications (medical, mental health, or non-health field):

Training

(Check any that you have training in)

Incident Command System

Other (list below):

Epidemiology

Bioterrorism

Terrorism and emergency response

Please describe any previous or current volunteer experience you have had:

Skills

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

Language Spoken

Level of Fluency (check one)

Read and Write?

Excellent Fair Poor

Yes No

Excellent Fair Poor

Yes No

Computer Skills (please specify):

Other Skills:

Deployment Preferences

(Please indicate your preferences by checking all that apply)

During an emergency where are you willing to serve?

In county only

Out of county – in state only

Only to neighboring counties

Out of state – USA only

What is the maximum number of days that you can be away? _____

Areas of Interest

(Please indicate your areas of interest by checking all that apply)

Licensed Volunteers

- | | |
|--|---|
| <input type="checkbox"/> Assist with Vaccinations | <input type="checkbox"/> Mental Health Consultation |
| <input type="checkbox"/> Pharmaceutical Distribution | <input type="checkbox"/> Medical Screening |
| <input type="checkbox"/> Direct Patient Care | <input type="checkbox"/> Other: _____ |

Licensed and Non-Licensed Volunteers

- | | |
|--|--|
| <input type="checkbox"/> Greet Clients | <input type="checkbox"/> Assist with Clinic Flow |
| <input type="checkbox"/> Register Clients | <input type="checkbox"/> Forms Completion and Collection |
| <input type="checkbox"/> Educate Clients (on procedure, clinic flow, etc.) | <input type="checkbox"/> Data Entry |
| <input type="checkbox"/> Language Interpreter | <input type="checkbox"/> Supply/Stock |
| <input type="checkbox"/> Computer Support | <input type="checkbox"/> Help Recruit More Volunteers |
| <input type="checkbox"/> Other: _____ | |

During a Non-Emergency Situation:

Work Directly with Patients/Clients

- | | | |
|---|---|---|
| <input type="checkbox"/> Assist with Flu Clinics | <input type="checkbox"/> Provide Patient Education | <input type="checkbox"/> Language Interpreter |
| <input type="checkbox"/> Assist with Dental Clinics | <input type="checkbox"/> Assist Patients with Forms | <input type="checkbox"/> Assist with children's health screenings |
| <input type="checkbox"/> Assist with other clinics (ex: TB screening) | | |
| <input type="checkbox"/> Other: _____ | | |

Provide Indirect Support

- | | |
|--|---|
| <input type="checkbox"/> Provide Health Program Assistance | <input type="checkbox"/> Provide education and/or presentations on Health Topics: (please list areas of topics you would like to speak about) |
| <input type="checkbox"/> Computer Support | _____ |
| <input type="checkbox"/> Clerical Assistance | _____ |
| <input type="checkbox"/> Other Administrative Assistance | _____ |

Please list any other areas you might be interested in serving:

Availability

Are you part of an emergency/disaster plan with any other organization? Yes No

(Ex: Red Cross, CERT, EMS, hospital, etc.)

If yes, please list those organizations below:

Other

Are there any special accommodations that you require that will enhance your experience as a MRC volunteer (i.e. TTY phones or large print documents)? Yes No

If yes, please describe: _____

Sex (check one) M F Age Bracket (check one) 18-25 26-40 41-64 65+

Shirt Size (check one) S M L XL 2X 3XL

Background Check

Have you ever been convicted of a misdemeanor? Yes No

Have you ever been convicted of a felony? Yes No

If yes, please describe: _____

A Criminal Background Check may be required of volunteers:

- YES, I acknowledge that a background check may be performed.

Print Name

Date

Signature

Date

Privacy Act Statement

This information is requested by the DeKalb County Board of Health 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.

Please return completed application to
Bill Atkinson
via fax at 404-294-3260, e-mail at wjatkinson@dhr.state.ga.us
or postal mail to: Bill Atkinson,
Office of Emergency Preparedness,
DeKalb County Board of Health,
Decatur, GA 30030