



STRAFFORD COUNTY CITIZEN CORPS VOLUNTEER APPLICATION

Application to (circle one):

- CERT (non-Medical or public health professionals)
Please fill out Supplemental CERT Application on page 5.
- Jr. CERT (Students under age 18).
- MRC (medical or public health professionals)
Please fill out Supplemental MRC Application on page 6.

PERSONAL INFORMATION

Name:

LAST *FIRST* *MI*

Address:

STREET *APT/STE* *CITY* *STATE* *ZIP*

Birthday:

Month *Day* *Year*

Please list the phone numbers we can contact you at AND identify the best sequence in which to contact you by circling the 1st, 2nd or 3rd under each number listed.

Telephone: () -	() -	() -	() -
<i>Home</i>	<i>Cell</i>	<i>Work</i>	<i>Other:</i> _____
<i>1ST 2ND 3RD</i>	<i>1ST 2ND 3RD</i>	<i>1ST 2ND 3RD</i>	<i>1ST 2ND 3RD</i>

Email:

1st 2nd 3rd

Email:

1st 2nd 3rd

Email:

1st 2nd 3rd

Emergency Contact Information:

Name:

LAST *FIRST* *RELATIONSHIP*

Address:

STREET *APT/STE* *CITY* *STATE* *ZIP*

Telephone:

HOME *WORK* *CELL*

REFERENCES

Please list two personal references not related to you:

<i>NAME</i>	<i>RELATIONSHIP</i>	<i>PHONE</i>	
<i>ADDRESS</i>	<i>CITY</i>	<i>STATE</i>	<i>ZIP</i>
<i>EMAIL ADDRESS</i>			

<i>NAME</i>	<i>RELATIONSHIP</i>	<i>PHONE</i>	
<i>ADDRESS</i>	<i>CITY</i>	<i>STATE</i>	<i>ZIP</i>
<i>EMAIL ADDRESS</i>			

PROFESSIONAL EXPERIENCE

Employment:

EMPLOYER (if applicable) FT PT RETIRED

SUPERVISOR *PHONE*

ADDRESS *CITY* *STATE* *ZIP* |

EMAIL ADDRESS

ADDITIONAL INFORMATION (OPTIONAL)

Do you hold a current driver's license?

YES NO *STATE:* *DL#:*

Are you part of any other emergency/disaster response/alert system? YES NO

PLEASE LIST:

Do you speak a foreign language? YES NO **Sign Language?** YES NO

Language(s) and Level:

Do you have teaching experience? YES NO **Leadership Experience?** YES NO

Do you have family obligations to consider before responding to an emergency? YES NO

Do you have medical insurance? YES NO

* SEE STRAFFORD COUNTY CITIZEN CORPS VOLUNTEER HANDBOOK FOR VOLUNTEER PROTECTIONS.

Medical Conditions, allergies, or information we should know about:

MEMBERSHIP LEVEL

Please choose one of the following volunteer opportunities that best describes how you would like to participate in the SCCC Program.

- SCCC Basic Member
 - Activated only in the case of a NH State Declared Emergency.
 - Notified of trainings and drills.
- SCCC Active Member
 - Activated for local and NH State Declared Emergencies
 - Called to help with special events and projects.
 - Notified of trainings and drills.
- SCCC Team Leader (*Eligible after one year of Active Member service*)
 - Activated for local and NH State Declared Emergencies.
 - Called to help with special events and projects.
 - Notified of trainings and drills.
 - Advisory and administrative duties.

WAIVER

All of the information I have supplied is correct to the best of my knowledge. I do hereby give the Strafford County Citizen Corps (SCCC) permission to make inquiries concerning my references, driving record, employment, licenses, certifications and police record. I hold Strafford County Citizen Corps harmless of any liability, whether civil or criminal, that may arise as the result of the information about me. I also hold harmless any individual, agency, business or corporation that provides information to Strafford County Citizen Corps. I recognize that I should investigate my personal and business liability coverage as it pertains to my volunteer service for the Strafford County Citizen Corps. I recognize that prior to being accepted as a volunteer, I may be required to provide additional documentation as proof of certain certificates (CPR, CDL, etc.).

I understand that I am a volunteer and will not be paid for any of my services.

I give permission for the Strafford County Citizen Corps to release personal information to local, state, and federal emergency management agencies and other Health and Human agencies as needed.

- I accept these terms.
- I do not accept these terms.

Signature: _____

Date: _____

PARENTS/GUARDIANS OF JR. CERT APPLICANTS

I give my child permission to participate in the Strafford County Citizen Corps Jr. CERT program. I understand that my son/daughter may be asked to assist emergency service and healthcare personnel in the event of an emergency.

- I give my child permission to participate in the Strafford County Citizen Corps Jr. CERT team.
- I do not give my child permission to participate in the Strafford County Citizen Corps Jr. CERT team.

Signature: _____

Date: _____

Please Return Completed Application To:

Strafford County Citizen Corps
PO Box 564
Rochester, NH 03866
Fax: (603) 953-0066



**STRAFFORD COUNTY COMMUNITY EMERGENCY RESPONSE TEAM
SUPPLEMENTAL VOLUNTEER APPLICATION PAGE**

SKILLS ASSESSMENT

To use your talents to the greatest benefit during an emergency, please indicate your skill level and/or willingness to perform activities in the following areas.

<p><u>ADMINISTRATIVE:</u></p>	<p><u>CARPENTRY/CONSTRUCTION:</u></p>	<p><u>PUBLIC SAFETY:</u></p>
<p><u>FOREIGN LANGUAGE AND SPECIAL NEEDS</u></p>	<p><u>LEADERSHIP/SUPERVISORY:</u></p>	<p><u>LICENSES/CERTIFICATE:</u></p>

Please describe briefly why you are joining the Strafford County Community Emergency Response Team and what you hope to gain from this experience:

* ALL VOLUNTEERS ARE REQUIRED TO UNDERGO A BACKGROUND CHECK. A SEPARATE DISCLOSURE AND RELEASE FORM WILL BE PROVIDED PRIOR TO CONDUCTING THE BACKGROUND CHECK.



**STRAFFORD COUNTY MEDICAL RESERVE CORPS
SUPPLEMENTAL VOLUNTEER APPLICATION PAGE**

Check your profession/occupation (all that apply)

- | | | | |
|--|----------------------------|--------------------------|-------------|
| <input type="checkbox"/> Physician: | _____ MD | _____ DO | |
| <input type="checkbox"/> Physician Assistant | | | |
| <input type="checkbox"/> Nurse: | _____ RN | _____ LPN | _____ LNA |
| <input type="checkbox"/> Nurse Practitioner | | | |
| <input type="checkbox"/> Educator (health/other) | | | |
| <input type="checkbox"/> EMT: | _____ Paramedic | _____ Intermediate | _____ Basic |
| <input type="checkbox"/> First Responder | | | |
| <input type="checkbox"/> Behavioral Health: | _____ Psychologist | _____ LSW | _____ LADAC |
| <input type="checkbox"/> Therapist: | | | |
| <input type="checkbox"/> Pharmacy: | _____ Pharmacist | _____ Pharmacy Tech | |
| <input type="checkbox"/> Dental: | _____ Dentist | _____ Dental Assistant | |
| <input type="checkbox"/> Laboratory: | _____ Medical Technologist | _____ Medical Technician | |
| <input type="checkbox"/> Veterinary: | _____ Veterinarian | _____ Vet. Tech. | |

Medical License #1

Type:	License #:
Issue Date:	Exp. Date:

Medical License #2 (if applicable)

Type:	License #:
Issue Date:	Exp. Date:

Medical License #3 (if applicable)

Type:	License #:
Issue Date:	Exp. Date:

Prescriptive Authority? YES NO

Specialty Area(s)

Hospital/Healthcare System Affiliation? YES NO

Name:

*** FOR CREDENTIALING PURPOSES, MRC VOLUNTEERS ARE REQUIRED TO REGISTER WITH THE EMERGENCY SYSTEM FOR ADVANCED REGISTRATION OF VOLUNTEER HEALTHCARE PROFESSIONALS (ESAR-VHP) AT WWW.ICANHELP.NH.GOV**