



## **VOLUNTEER APPLICATION**

Thank you for your desire to **ACTIVATE, RESPOND, and MAKE A DIFFERENCE** in New Orleans. You will be part of a vital program designed to mobilize a trained medical support unit to augment emergency operations and responses during man-made or natural disasters and address community needs on a day to day basis. This information will be registered in the database system, ESAR-VHP, Emergency Systems for Advanced Registration of Volunteer Health Professionals and LAVA, Louisiana Volunteers in Action.

<b>Section 1: Personal Contact Information</b>		
Name:		
Home Address:		
City:	State:	Zip:
Email Address:		
<b>Section 2: Occupation</b>		
Occupation:		
Degree and/or Specialization:		
Employer:		
<b>Section 3: What is the best way to contact you for deployment during an emergency?</b>		
Primary Contact:    Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Primary number: _____		
Secondary Contact:    Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Secondary number: _____		
<b>Section 4: Prior Commitments to Emergency Response</b>		
Do you have any military or civil service obligations in the event of an emergency? Yes    No If yes, explain:		
Are you part of an emergency/disaster plan with any other organization? Yes    No If yes, explain:		
Do you have other commitments that might pose a conflict in the event of an emergency? If, yes, please identify them below:		
<b>Section 5: License (professionals with a current license or certification in any health or mental health field please attach copies of your current professional license to this application)</b>		
<b>License</b>	<b>License/Certification #</b>	<b>Expiration Date</b>
<b>Do you have prescriptive authority?</b> Yes    No		



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<b>Section 6: Emergency Contact</b>	
Name:	<b>Relationship:</b>
Phone Number:	
Email Address:	
Home Address:	

### **ACKNOWLEDGMENT RELEASE OF CONFIDENTIAL INFORMATION**

This signed document authorizes the New Orleans Medical Reserve Corps (NOMRC) to release any necessary contact information to members of the Medical Reserve Corps (MRC) for the purpose of contacting you in the event of NOMRC activation.

By signing this release you are acknowledging that your name, phone numbers, e-mail and fax numbers will be released and made public to MRC personnel and volunteers.

You also acknowledge and agree that as a member of the NOMRC, you will not use any contact information you receive about any other NOMRC volunteer for any purpose other than official Alert notification(s) to other NOMRC volunteers.

I do hereby give the NOMRC permission to inquire into my educational background, references, driving record, employment, volunteer history and police record.

I also grant permission for this information to be used by the NOMRC to contact me concerning issues of NOMRC training and other administrative subjects.

1. I understand that I have the right to refuse to release this information. If I refuse to release this information, it will not be possible for this office to process my application with the Medical Reserve Corps.
2. I understand that I may withdraw this consent upon written notice.
3. I hold the New Orleans Medical Reserve Corps harmless of any liability, criminal or civil, that may arise as a result of the release of this information about me. I also hold harmless any individual or organization that provides information to the above-named agency.
4. I do hereby give the New Orleans Medical Reserve Corps permission to release my personal information as needed for training and/or deployment of the Medical Reserve Corps.

Further, I understand the accuracy of the information I present to the New Orleans Medical Reserve Corps is critical. To the best of my knowledge, all of the information provided in this document is correct and answered completely to the best of my ability. Should the information I provide change, I pledge that I will update my profile as quickly as possible to ensure the MRC volunteer database is current. **I understand a background check and sexual predator check may be conducted using information I have provided.**

I hereby certify that all statements made in this application are true and I agree and understand that any misstatement of material facts may cause forfeiture of my eligibility for enrollment as a health professional reserve volunteer. I also understand that falsification or omission of information may result in my removal from eligibility as a volunteer. I understand that submitting this application does not guarantee selection for placement.

\_\_\_\_\_  
Signature of Volunteer

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date