Auglaize County Medical Reserve Corps
Volunteer Registration Form

Last Name:	First Name:	M.I.:	Credentials
Home Address:	City:	State:	Zip:
Business Address:	City	State:	Zip:
Home Phone: / Business Phone:	D.O.B / /	Cell Phone:	
E-mail address:			

Male ____ Female ____	Veteran of Military Service? Yes ____ No _____	**All ACMRC members are also encouraged to become Auglaize Co. Citizens Emergency Response Team members**

Medical Volunteer Opportunities: From the list below, please indicate your medical profession

☐ Chiropractor	☐ Massage Therapist	☐ Pharmacist Asst	☐ Respiratory Tech.
☐ Dentist	☐ Med. Lab. Tech	☐ Physical Therapy Tech.	☐ Social Work
☐ Dental Hygienist	☐ Medical Asst	☐ Physician	☐ Veterinarian
☐ EMT - Advanced	☐ Nurse	☐ Physician Asst.	☐ Veterinarian Tech.
☐ EMT - Basic	☐ Occ. Therapy Tech.	☐ Psychiatrist	☐ Other
☐ Health Information/ Medical Records	☐ Paramedic	☐ Psychologist	☐ Non-Medical
	☐ Pharmacist	☐ Radiology Tech.	☐

Clergy, Language Interpreters or other licensed persons, please specify:

_____

Emergency Contact information

Name	Relationship	Address	Phone

Volunteer Consent for Reference and Background Check

I do hereby grant the Auglaize County Health Department permission to inquire into my educational background, references, driving record, police records, employment, and/or volunteer history. I further give permission to the holder of any such records to release the same to the Auglaize County Office of Homeland Security and Emergency Management Agency and to the State of Ohio's Medical Reserve Corps.

I do hereby hold Auglaize County Health Department and its member affiliates harmless from any liability whether civil or criminal that may result from the release of this information about me. I further hold harmless any individual, agency, business or corporation that provides information or documents to the above names. I understand that the Auglaize County Health Department and/or the Auglaize County Medical Reserve Corps will use this information as part of its verification of my volunteer application and periodically for evaluation purposes.

_____ _____

Signature Date

Complete and return to:
Attn: Don Jump, CHEP Auglaize County Health Department 813 Defiance St. Wapakoneta, Ohio 45895
E-mail: djump@auglaizehealth.org Office: (419) 738-3410 Fax: (419) 738-7818