



County of Alameda Public Health Department
Medical Reserve Corp Volunteer Program



Public Health Emergency Preparedness
1000 Broadway Suite 500, Oakland, CA 94607
(510) 268-7023 Fax: (510) 273-3714 ALCOPHEPMRC@acgov.org

ALCO MRC Volunteer Application

Position of Interest: MEDICAL RESERVE CORPS		Date:
First Name:	Last Name:	Home Phone:
Address:		Cell Phone:
City:	State, Zip Code:	Work Phone:
E-mail address:	Prof. License Number:	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Other
JOB DESCRIPTION		
Check all that apply to you:		
<input type="checkbox"/> MD	<input type="checkbox"/> RN	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Pharm D	<input type="checkbox"/> EMT	<input type="checkbox"/> MSW
<input type="checkbox"/> Resp Therapist	<input type="checkbox"/> LCSW	<input type="checkbox"/> Psych Tech
<input type="checkbox"/> Paramedic	<input type="checkbox"/> PA	<input type="checkbox"/> DDS
<input type="checkbox"/> MFT	<input type="checkbox"/> LVN	<input type="checkbox"/> Non-licensed
<input type="checkbox"/> DO	<input type="checkbox"/> DVM	<input type="checkbox"/> Other:
<input type="checkbox"/> NP	<input type="checkbox"/> DC	
SUMMARIZE YOUR WORK HISTORY		
Current job title & employer:		Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>
Brief summary of employment history:		
RELEVANT EDUCATION		
Educational Institution(s) Attended: _____		Date(s): _____
Major(s): _____ Minor(s): _____ Degree(s) earned: _____ (B.A, B.S, M.P.H, ETC.)		
RELEVANT COURSE WORK, COMPUTER, SPECIAL SKILLS, CERTIFICATES OR LICENSES (CPR/AED, BLS, ETC.)		
GOALS through volunteering (contribute to the community, gain work experience, school credit...)		
VOLUNTEER EXPERIENCE (briefly summarize your volunteer history, if applicable)		

BACKGROUND CHECK

If the position for which you are applying requires a background check, please answer the following questions:

Have you ever had a certification, accreditation, or professional healing arts license denied, suspended, revoked or placed on probation, or are you under investigation at this time? Yes No

If yes, you must enclose with this application a written explanation that describes the action, any corrective action, and/or remediation as a result of the action.

HOW DID YOU LEARN ABOUT THE PROGRAM?

- | | |
|---|---|
| <input type="checkbox"/> County Employee | <input type="checkbox"/> County Volunteer |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> Local Event |
| <input type="checkbox"/> Newspaper: | <input type="checkbox"/> Posted Bulletin |
| <input type="checkbox"/> Website (http://www.acphd.org/alcomrc.aspx): | <input type="checkbox"/> Other: |
| <input type="checkbox"/> School: | |

General Photography Release Consent

I do not object to the ALCO MRC taking photos of my likeness during training/activation and potentially using the images in training and outreach materials. I understand that it is my responsibility to alert the photographer if I object to the taking of my photo.

I hereby certify that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to membership in the Alameda County MRC. I understand all information on this application is subject to verification, and I hereby give my express permission for the County of Alameda to contact any person, agency or institution for information related to my role and function as a Medical Reserve Corps volunteer. I hold Alameda County 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 Alameda County.

Signature of Applicant: _____ Date: _____

Confidentiality Statement

In the course of volunteering with Alameda County Medical Reserve Corps, I understand that I will come across personal and health information of patients. I acknowledge that it is my duty to protect said information at all times. I agree that I will not disclose any information which I may obtain in the course of my duties to unauthorized individuals and will share this information only with those who must have that information to assist in or take over that patient's care. I understand that this obligation applies even after I have completed my duties as a volunteer.

I, _____ by my signature below, will protect and comply with state and federal confidentiality laws and the privacy rights of patients for whom I provide or assist in the provision of medical or personal care.

Signed:

[Printed Name]

[Signature]

[Date]