

Northeast Ohio Medical Reserve Corps, Inc

Membership Application



Please print clearly

<http://www.neomrc.org>

info@neomrc.org

Personal Contact Information

Last Name _____ First Name _____ MI _____ Dr. Mrs. Mr. Ms. (Circle one above)

Maiden name/other names used: _____ OH Driver's License # _____ Date of Birth: _____

Home Address: Street _____ Apt. # _____

County _____ City _____ State _____ Zip Code _____

Home Phone # () _____ Cell Phone # () _____ Home Fax # () _____

E-mail Address _____ Personal Pager # () _____

Amateur Radio Callsign: _____ License Class: _____

Have you ever been convicted of a felony? **Y** **N** A misdemeanor? (other than traffic violations) **Y** **N**
If yes please explain:

In case an emergency happens **to me** please contact:

Name: _____ Relationship: _____

Daytime phone number: _____ Evening phone number: _____

Do you have any personal health issues that would impact your ability to volunteer? **Yes** **No**
(For example allergies, medication issues, disabilities, special needs, or being treated for a medical condition) If yes, please either list here or speak personally with the MRC Coordinator.

Work Contact Information

Occupation _____ (check) Full Time Part Time Retired Student

Employer _____ Address _____

General Phone Number () _____ Your extension _____ Fax # () _____

In the event volunteers are called 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 above.

Contact _____ Phone Number () _____ Relationship _____

Education

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

School Name: _____ Location: _____

Type of Degree: _____ Major/Specialization: _____ Year Graduated: _____

License

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

Circle all applicable:

State Issued

Expiration Date

1. M.D./ D.O. _____
2. D.D.S./D.M.D. _____
3. D.C. _____
4. R.N. _____
5. L.P.N. _____
6. EMT/ Paramedic _____
7. P.A/ N.P. _____
8. Other health related degrees or licenses _____

***** Please attach a copy of your current professional license to this application. *****

Certifications & Training

(Check any that apply)

Certifications

CPR

First Aid

Disaster Training

CERT

Bloodborne Pathogens &
Standard Precautions

Other Certifications

Most Recent Date

Certifying Agency

Training (Check any that you have attended)

Incident Command System

Epidemiology

Bioterrorism

Terrorism & emergency response to terrorism

Other Training (list below)

Are you part of an emergency/disaster plan with any other organization? (Such as the American Red Cross, a local hospital, etc.)

If yes, please list below.

Yes

No

Other skills that may be beneficial to the Northeast Ohio Medical Reserve Corps?

How did you learn about the Northeast Ohio Medical Reserve Corps?

I hereby certify that all of the information submitted on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered my application may be rejected and if I am a member and any of these items are later discovered I my membership may be terminated at any time.

In consideration of my membership, I agree to conform to all of the rules, regulations, standard operating procedures and guidelines of the Northeast Ohio Medical Reserve Corps and agree that my membership can be terminated without notice at any time at either my or the Northeast Ohio Medical Reserve Corps option. I further understand that the terms and conditions of membership may be changed without or without cause or notice at anytime by the Northeast Ohio Medical Reserve Corps Board of Trustees.

I further authorize you (should the need arise) to investigate my personal and or criminal history, as you deem necessary.

Signature of applicant

Date

Please return application form to:
Northeast Ohio Medical Reserve Corps, Inc
P.O. Box 33524
Cleveland, Ohio 44133

Enclose first year membership dues of \$20 (check made payable to *Northeast Ohio Medical Reserve Corps, Inc.*) and this signed form to the address shown above. In the event you are not accepted for Membership your check will be returned.

Approved _____

Denied _____

Date & Initials _____

Membership Classification:

- Full Member
- Associate Member
- Communications Member
- Honorary Member
- Auxiliary Member
- Volunteer