Northeast Ohio Medical Reserve Corps, Inc
Membership Application

Please print clearly

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 # (_____) ____________ Alt Phone # (____) ________________

E-mail Address____

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

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Emergency 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.

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Work Information

Occupation ______________________________ (check) ❑ Full Time ❑ Part Time ❑ Retired ❑ Student

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

Type of Medical Licenses (if any), State Issued, Expiration Date

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

Certifications & Training (Check any that apply)

Certifications	Most Recent Date	Certifying Agency
❑ CPR		
❑ First Aid		
❑ Disaster Training		
❑ Other Certifications		

Amateur Radio Callsign:__________________________ License Class: ___________________________

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

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

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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:

akocab@neomrc.org
info@neomrc.org

Approved ________________________

Denied __________________________

Date & Initials_____________________

Membership Classification:

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