



Attachment B

1. Contact Information:

First Name: _____ Middle Name: _____ Last Name: _____

Gender: M F

Home Address: _____

City: _____ State: DE Zip Code: _____

Mailing Address: (if different from above) _____

City: _____ State: DE Zip Code: _____

County you live in: _____ County you work in: _____

Home Phone Number: _____ - _____ - _____ Cell Phone Number: _____ - _____ - _____

Work Phone Number: _____ - _____ - _____ Pager Number: _____ - _____ - _____

Primary Email Address: _____

Alternate Email Address: _____

Date of birth: month/day/year ____ / ____ / ____

Driver's License / ID No: (state) ____ (number) _____

2. What is the best way to contact you in the event of an emergency?

2a. Primary contact: Home Phone Cell Phone Pager Email

2b. Secondary contact: Home Phone Cell Phone Pager Email

3. Do you have any military service obligations in the event of an emergency?

Yes No

If yes, please explain what they are (maximum 200 characters allowed)





4. Do you have any other commitments that might pose a problem in case of an emergency?

Yes No

If yes, please identify:

Red Cross:

Hospital / Clinic: (insert facility name) _____

First Responder: Fire Service Law Enforcement EMS Haz Mat

Other: _____

5. What is your employment status?

Full Time

Part Time

On Call

Not Employed

Retired

Student

6. Do you work at more than one location?

Yes No

7. In what type of setting do you work?

Health Care Settings:

Clinic

Home Care/Hospice

EMS Provider

Laboratory

Assisted Living

Nursing Home

Rehabilitation

Pharmacy

Physician Practice: (please specify specialty) _____

Other: (please specify) _____

Hospital Settings:

Emergency Room

Intensive Care

Medical/Surgical

Laboratory

X-ray

Other diagnostic procedures: (please specify) _____

OB/GYN

Operating Room/Recovery Room

Pediatrics

Rehabilitation

Pharmacy

Psychiatric / Behavioral Care / Mental Health

Other: (please specify) _____

Other Settings:

Academic

Correctional Facility

Group Home

Emergency Communications

Church

School

Public Safety / Police Department

State Government: (please specify Department and Agency) _____

Other: (please specify) _____





8. In what types of activities are you involved on your job?

(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Clinical Services |
| <input type="checkbox"/> Education/Teaching | <input type="checkbox"/> Disease Investigation and control |
| <input type="checkbox"/> Environmental Health | <input type="checkbox"/> EMS medical direction/coordination |
| <input type="checkbox"/> Epidemiology | <input type="checkbox"/> First responder |
| <input type="checkbox"/> Health counseling | <input type="checkbox"/> Health education or promotion |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Insurance/utilization review |
| <input type="checkbox"/> Patient care | <input type="checkbox"/> Medical priority dispatching |
| <input type="checkbox"/> Program planning | <input type="checkbox"/> Quality improvement/assurance |
| <input type="checkbox"/> Research | <input type="checkbox"/> Supervision |
| <input type="checkbox"/> Telephone triage | <input type="checkbox"/> Finance |
| <input type="checkbox"/> Security | <input type="checkbox"/> Other: (please specify) _____ |

9. Are you willing to travel to other parts of the state to assist with an emergency?

- Yes No

10. Do you speak any of these foreign languages?

- Yes No

If yes, please list what languages and proficiency in each (limited, intermediate, advanced):

- a. _____
- b. _____
- c. _____

11. Do you know American Sign Language?

- Yes No

12. Have you had HAZMAT (hazardous materials) training?

- Yes No

If yes, please indicate training level:

- Awareness
- Operations
- Technician
- Specialist

13. Have you had basic first aid training?

- Yes No

If yes, please indicate year of most recent training: _____





14. Have you been trained in CPR?
 Yes No
If yes, please indicate year of most recent training: _____

15. Have you had incident command training?
 Yes No
If yes, please indicate year of most recent training: _____

Please answer the following questions if you are a health care professional.
(If not, please proceed to the end of the application for signature.)

16. Do you have training and experience in starting an IV?
 Yes No
If yes, please indicate year of most recent training: _____

17. Do you have training and experience in giving IV medications?
 Yes No
If yes, please indicate year of most recent training: _____

18. Do you have training and experience in giving IM medications?
 Yes No
If yes, please indicate year of most recent training: _____

19. Do you have training and experience in using equipment to manage a person's airway?
 Yes No
If yes, please indicate year of most recent training: _____

20. Have you received formal paramedic training or military medical training?
 Yes No
If yes, please indicate year of most recent training: _____

21. Are you currently or have you previously been credentialed by one of the State of Delaware health professional Boards (example, Board of Nursing)?
 Yes No
If yes, please indicate which Board: _____





22. If you are credentialed by a state board, what is the status of your primary license, registration, or certification?

- Active
- Inactive
- Other

If you currently have a license, please complete the following:

(This information will only be used for credentialing purposes)

License, Registration, or Certification Number: _____

Expiration Date: month/day/year ____ / ____ / ____

23. Do you have current or previous experience in a healthcare occupation that is not currently licensed, registered, or certified in the State of Delaware?

- Yes No

If yes, please indicate your primary occupation: _____

24. Briefly describe the educational, volunteer, or work experience you believe you have that is relevant to volunteering in the event of a public health emergency.

25. How did you hear about the opportunity to become a member of the Delaware Medical Reserve Corps?

- | | | |
|---|--|--|
| <input type="checkbox"/> Brochure/Flyer | <input type="checkbox"/> Internet | <input type="checkbox"/> Professional Organization |
| <input type="checkbox"/> Presentation | <input type="checkbox"/> TV / Radio | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> Mailing | <input type="checkbox"/> Article/Publication | <input type="checkbox"/> Other: _____ |





Acknowledgement

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 Medical Reserve Corps volunteer. I also understand that falsification or omission of information may result in my removal from eligibility as a volunteer. I understand that the information from this application may be shared with federal, state, regional, or local partners in planning for emergency preparedness and with those agencies where I will be placed as a volunteer. I authorize the State of Delaware Public Health Medical Reserve Corps officials to check any information regarding my application and information about criminal background and will agree to submit a separate form indicating authorization to release this information, if necessary. I understand that I have the right to withdraw my application or discontinue my enrollment as a volunteer at any time with written notification to the Delaware Division of Public Health Medical Reserve Corps officials.

By signing this application, I agree to the statement above.

Signature: _____

Date: _____



Delaware Health and Social Services
Division of Public Health
Public Health Preparedness Section

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