



# GREATER FALL RIVER MEDICAL RESERVE CORPS



Member of the Bristol County Medical Reserve Corps Collaborative

Serving the Communities of  
Fall River, Somerset, Swansea and Westport

## VOLUNTEER APPLICATION FORM

### **1. Demographic Information:**

Last Name	First Name	MI
Primary Area of Employment (i.e. Public Health, Teacher, Computers, etc.)		
Employer (Former, if Retired)		
Drivers License/Class/State		Gender: Male ____ Female ____

### **2. Contact Information:**

Home Address		
Street	Apt. #	
City	State	Zip Code
Mailing Address (if different from above)		
Street	Apt. #	
City	State	Zip Code
Primary Email Address		
Alternate Email Address		
Daytime Phone		
Mobile Telephone		

### **3. Emergency Contact:**

Name	Relationship	Name	Relationship
Address		Address	
Phone Number		Phone Number	

### **4. Personal Health:** (for deployment purposes)

Please list any health problems or physical restrictions: _____ _____ _____
Are adaptations required? _____ _____ _____

**Please include copy of vaccinations or proof of immunity, if available.**

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<input type="checkbox"/> Counseling/Mental Health	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Dental Assistant	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Pharmacy Technician
<input type="checkbox"/> Epidemiology	<input type="checkbox"/> Physician
<input type="checkbox"/> Epidemiology (Nurse)	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> EMT/Paramedic	<input type="checkbox"/> Toxicologist
<input type="checkbox"/> Lab Technician	<input type="checkbox"/> Veterinarian
<input type="checkbox"/> Nurse	<input type="checkbox"/> Vet Tech
<input type="checkbox"/> Nurse (Clinical Specialist)	<input type="checkbox"/> Non-clinical Staff
<input type="checkbox"/> CNA, LPN	<input type="checkbox"/> Police Officer
<input type="checkbox"/> Fire Fighter	<input type="checkbox"/> Clergy/Chaplain
<input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Environmental Services
<input type="checkbox"/> Clinical/Medical Student (please specify school, program of study, and graduation date) _____	

**Please indicate any applicable degrees (i.e. MD, RN)** \_\_\_\_\_

Are you currently licensed and/or certified to practice in Massachusetts?  
 Yes    Licensing Agency: \_\_\_\_\_    License # \_\_\_\_\_  
 No     N/A

Have you ever had your professional license suspended or revoked?    Circle one:    Yes    No  
If yes, attach letter of explanation.

Please indicate any affiliation with health care organization (hospital, health center, visiting nurse association)  
\_\_\_\_\_

Other Licenses/Certifications \_\_\_\_\_

**6. Skills/Areas of Expertise** (Check all that apply)

Case Management (Non-Clinical)	Driver/Delivery	Media/Public Relations
Clinical/Nursing Case Management	Events Organizer	Mental/Behavioral Health
Child Care Provider	Food Preparer	Outbreak Investigation
Communications	Fund raising	Patient Advocacy
Communicable Disease	Hazardous Materials	Phlebotomy
Community Organizing	Health Education	Phone Bank
Compassionate Provider	Home visiting	Provider Education
Counseling	Inspection	Public Safety
Crisis Intervention	Interviewing	School Health
Customer Service	Logistics	Triage
Data Analysis	Materials Management	Vaccination
Data Entry	Maternal/Child Health	Spiritual Care

**7. Language:** Please indicate languages spoken and circle level of proficiency.

Language	Speaking	Reading	Writing	Medical Interpretation
1)	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair
2)	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair
3)	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair
4) American Sign Language	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair	Fluent Good Fair

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**\_\_\_ Response/Inactive Level:** Response Level involves a minimal time commitment. Members are only asked to volunteer in the event of a mass emergency. You are required to complete two 1 \_ hour trainings, which can be done in person or online. If activated, volunteers will receive training specific to the event before being assigned to a deployment.

**\_\_\_ Active Level:** Active Level involves slightly more time commitment. In addition to the initial mandatory trainings you plan to attend other trainings of your choice. A minimum of two trainings/meetings a year is required to maintain active level. If activated, volunteers will receive training specific to the event before being assigned to a deployment.

**\_\_\_ Leadership Level:** Leadership Level is open to those who want a role in management of a clinic or a part of a clinic. There is a larger training commitment, requiring 10-15 hours of training in addition to the initial orientation. You may also want to be involved in your local chapter at the council level. If activated, volunteers will receive training specific to the event before being assigned to a deployment.

**9. References:** Please provide 2 references. For licensed applicants, at least 1 professional reference is preferred from a current employer or colleague.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about the Greater Fall River Medical Reserve Corps?**

a) Brochure \_\_\_\_\_ b) Friend or colleague \_\_\_\_\_

c) Website \_\_\_\_\_ d) Professional organization \_\_\_\_\_

e) Other \_\_\_\_\_

**Volunteer Consent for References, Background Checks,  
Release of Information and Media Waiver**

I understand that the information on this application will be kept confidential. I do hereby give the Greater Fall River Medical Reserve Corps permission to inquire into my background, including references, employment, licensure, driving record, police record, education and/or volunteer history as part of the verification/application process. I further give permission to the holder of any such records to release the same to the GFRMC.

Additionally, I do hereby consent to the release of personal information to local, state and federal emergency management and other Health and Human services agencies as needed. I further understand I will be required to sign a CORI request form. I understand that as a Medical Reserve Corps volunteer I am not paid for my services.

I further understand that I will be required to sign a Code of Conduct upon approval of my application and that the MRC may develop, participate in or be the subject of media based presentations and events and give my permission to publish my name and photograph with any MRC activity. I hereby hold the MRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of information about me. I further hold harmless any individual, agency, business or corporation that provides documents to the MRC.

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**Assumption of Risk**

I recognize that the Volunteer Medical Corps may involve physical labor and may carry a risk of personal injury. I further recognize that there may be natural and manmade hazards, environmental conditions, diseases and other risks, which in combination with my actions could cause injury to me. I hereby agree to assume all risks, which may be associated with or may result from my participation in this volunteer program.

**Release**

I hereby release the GFRMRC and the "Hosting Community", its agencies, departments, officers, employees, agents and assigns, from any and all liability, claims, demands, actions, and causes of action whatsoever for any loss claim, damage, injury, illness, attorney's fees or harm of any kind or nature to me arising out of any and all activities associated with this volunteer program.

Signature of Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Please fax or mail this form to the address below. Thank you for your interest in the Greater Fall River Medical Reserve Corp.**

**GFR. MRC-Westport**

Nancy J. Paquet, Principal Clerk  
Kathleen Burns, RN  
James J. Walsh, Jr., Sr. Health Agent  
Westport Board of Health  
856 Main Road  
Westport, MA 02790

Phone: (508) 636-1015  
Fax: (508) 636-1016  
Email: Health@Westport-MA.gov

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FYI

**GFR. MRC Head Quarters**

Heather Salva  
Greater Fall River MRC  
c/o Fall River Health & Human Services  
One Government Center, 4<sup>th</sup> floor  
Fall River, MA 02722

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