VOLUNTEER APPLICATION

Please print or type

Name			
Street Address (Mailing)			
City		**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
Email		**Employer**	

Type of Medical Professional:

- ❑ Physician
- ❑ Nurse
- ❑ Pharmacist
- ❑ Psychologist
- ❑ Dentist
- ❑ Veterinarian
- ❑ Mental health
- ❑ Social worker
- ❑ EMT
- ❑ Non Medical
- ❑ Other_____

_____

Emergency contact information:

Name:
Address:

Home #
Cell #

License or Certificate / Registration Number:

Languages:

Drivers license #

State License(s) Held:

Expiration Date:

Level of Participation Desired - I prefer to be:

- ❑ **ACTIVE** Receives notifications of ALL training opportunities, training drills & exercises, emergency events, as well as non-emergency volunteer opportunities
- ❑ **LIMITED** Receives only notification of training drills and exercises and all emergency events

Volunteer Interests: ***Check all that apply***

Administration	☐	**Steering Committee**	☐	**Newsletter Production**	☐	**Clerical**	☐
Public Safety	☐	**Fundraising**	☐	**Volunteer Coordination**	☐	**Deliveries**	☐
Phone Bank	☐	**Information Technology**	☐	**Behavioral Health**	☐	**Clinical**	☐

A Criminal and Sexual Offense Background Check is required of all volunteers:

I do hereby give Region 4a Medical Reserve Corps permission to release personal information with local, state and federal emergency management agencies and other Health and Human Service agencies as needed.

Birth Date ___/___/___ Social Security #_____ Signature _____Date___/___/___

Location Preference for Responding: ***Check all that apply***

Hudson Only	☐	**Region 4A**	☐	**New England**	☐	**National**	☐
Towns adjacent to Hudson	☐	**Massachusetts**	☐	**East Coast**	☐	**Worldwide**	☐

Signature	**Date**

Privacy Act Statement

This information is requested by Region 4a Medical Reserve Corps and is for the purpose of organizing volunteers and staff to respond to public health emergencies. It will not be utilized or released for any other purpose without your express written permission unless required by law and all information will be kept in a secure manner.

Please submit to:

Hudson Board of Health
78 Main Street, Hudson, MA 01749
Tel: (978) 562-2020 Fax: (978) 562-8508
Email: swong@townofhudson.org

BOARD OF HEALTH

78 Main Street, Hudson, Massachusetts 01749
Phone (978) 562-2020
Fax (978) 562-8508

CORI Request form

The Town of Hudson has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. I understand that a criminal record check will be conducted for conviction, non-conviction and pending criminal case information only and that it will not necessarily disqualify me.
The information is correct to the best of my knowledge:

Applying for the position of: Hudson Medical Reserve Corps Volunteer

Applicant's signature: _____

Applicant's Information (Please print)

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____
Maiden Name or Alias Place of Birth Date of Birth

_____ _____
Social Security Number Mother's Maiden Name

Current Address: _____

_____

Former Address: _____

_____

Sex: __ Height: ___Weight:__ Eye Color: ____ State Drivers license #_____

THE ABOVE INFORMAITON WAS VERIFIED BY REVIEWING THE FOLLOWING OF GOVERNMENT ISSUED PHOTOGRAFIC IDENTIFICATION: _____

Requested by: _____
Signature by CORI representative