



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:

<input type="checkbox"/> Physician	<input type="checkbox"/> Mental health
<input type="checkbox"/> Nurse	<input type="checkbox"/> Social worker
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> EMT
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Non Medical
<input type="checkbox"/> Dentist	<input type="checkbox"/> Other _____
<input type="checkbox"/> Veterinarian	

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 <input type="checkbox"/>	Steering Committee <input type="checkbox"/>	Newsletter Production <input type="checkbox"/>	Clerical <input type="checkbox"/>
Public Safety <input type="checkbox"/>	Fundraising <input type="checkbox"/>	Volunteer Coordination <input type="checkbox"/>	Deliveries <input type="checkbox"/>
Phone Bank <input type="checkbox"/>	Information Technology <input type="checkbox"/>	Behavioral Health <input type="checkbox"/>	Clinical <input type="checkbox"/>

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 <input type="checkbox"/>	Region 4A <input type="checkbox"/>	New England <input type="checkbox"/>	National <input type="checkbox"/>
Towns adjacent to Hudson <input type="checkbox"/>	Massachusetts <input type="checkbox"/>	East Coast <input type="checkbox"/>	Worldwide <input type="checkbox"/>

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