



VOLUNTEER APPLICATION

Please print neatly

Last Name	First Name	M.I.	Sex
Street Address (and mailing address, if different)			
City	State	Zip	
Home Phone #	Work Phone #	Cell Phone # and Provider (for text alerts)	
Email @		Employer	

Type: Medical Professional <small>(i.e. MD, RN, PA, NP, Pharmacist, EMT, Paramedic, Respiratory Therapist, Mental Health, etc.)</small>	Type: Non-Medical <small>(i.e. Administration, Clerical, Security, etc.)</small>	Requested means of communication: <input type="checkbox"/> Mail to above address <input type="checkbox"/> Email to above <input type="checkbox"/> Other (specify) _____
For All Healthcare Professionals: Please indicate License Number or Certificate/Registration Number		Other Languages spoken
#	Valid: <input type="checkbox"/> Yes <input type="checkbox"/> No Exp. Date / /	State License Held Degree(s) Obtained

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

EMERGENCY ONLY Receives notification of only major emergency events

NOTE: All volunteers are required to take the orientation training and ICS 100 & 700 prior to participation in training drills and exercises. In addition, CPR & First Aid must be current in order to participate in actual emergency responses and/or activations.

Do you have any current or pending actions against your professional license? Yes No

I understand that a Background Check is required of all volunteers. Initials _____

- Have you ever been convicted of a misdemeanor? Yes No
- Have you ever been convicted of a felony? Yes No
- Do you have any other legal judgments in force? Yes No

Birth date ___/___/___ **Other Names Used** _____

If you answered YES to any questions under the background check segments please include a description of the issue, date(s), and jurisdiction where it occurred in this section (you may continue on the back of the application):

Signature	Date
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Please email to: kristen.sailer@co.saint-croix.wi.us or
Fax: 715-386-4720 or
Mail to: Saint Croix County Medical Reserve Corps
Attn: Kristen Sailer, Coordinator
Government Center, 1101 Carmichael Road, Hudson, WI 54016