



A • V • M • R • C
ALLENTOWN VOLUNTEER MEDICAL RESERVE CORPS



Health Care Professional Volunteer Application

Date of Application: _____

Which classification best describes you? (Choose one)

- Health Care Professional (medical)
 Community Health Volunteer (non-medical)

Personal Information

Last Name:		Middle Name:	
First Name:		Nickname:	
Date of Birth (m/d/yyyy):			
Street Address:			
City:		State:	
Zip:		County:	
Mailing Address (if different):			
City / State / Zip:			
Note: Please enter at least one Phone No.			
Phone : Home _____ Work _____ Cell _____ <i>Circle the preferred number to reach you.</i>			
E-mail where you want to receive messages:			
Do you possess a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No			
State:	Class:	Driver's License Number:	Expiration Date:

Employment Information

Place of Employment (previous if retired):
Work Address:
City / State / Zip:

Emergency Contact - Will be notified in case of an emergency.

Last Name:		First Name:	
Relationship:			
Street Address:			
City / State / Zip:			
Note: Please enter at least one Phone No.			
Phone : Home _____ Work _____ Cell _____ <i>Circle the preferred number to reach your emergency contact.</i>			

Additional Information

Languages:	Fluent?	Speak?	Read?	Write?
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Question	Comment
Are you willing to travel and volunteer outside of your county? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you willing to participate in a Federally coordinated emergency response? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Willing to provide translation service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have ability to communicate using sign language? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been immunized against Smallpox? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Year of most recent smallpox vaccination:	
Do you have any special needs or restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.	
Are you committed to any other organization or institution, by virtue of employment or volunteerism, in the event of a public health emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.	
Do you have particular expertise and agree to be available for consultation or response throughout the state? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your professional license or certification ever been suspended or revoked in Pennsylvania or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Professional Licensure, Certification, Specialties, Experience

Name on License/ Certification:	Active? <input type="checkbox"/> Yes <input type="checkbox"/> No
License/Certification Number:	State on License/Certification:
Specialty (or Subspecialty) within the above professional licensure/certification that you possess:	

Training/Continuing Education

Have you completed any training or continuing education programs in the following areas? If so, please check.

- | | |
|--|--|
| <input type="checkbox"/> Advanced Cardiac Life Support (ACLS)
<input type="checkbox"/> Hazardous Materials Training (HAZMAT) Biological
<input type="checkbox"/> Advanced Trauma Life Support (ATLS)
<input type="checkbox"/> Hospital Preparedness
<input type="checkbox"/> Basic Cardiac Life Support (BLS)
<input type="checkbox"/> Incident Command Training (ICS)
<input type="checkbox"/> Basic Disaster Life Support (BDLS)
<input type="checkbox"/> Isolation and Quarantine
<input type="checkbox"/> Bloodborne Pathogens
<input type="checkbox"/> Mental Health Training for Disasters
<input type="checkbox"/> Pediatric Advanced Life Support (PALS)
<input type="checkbox"/> Citizen Emergency Response Team (CERT) Training | <input type="checkbox"/> Triage
<input type="checkbox"/> CPR/AED
<input type="checkbox"/> Vaccination administration smallpox
<input type="checkbox"/> Exercise design and evaluation
<input type="checkbox"/> Vaccination administration
<input type="checkbox"/> First Aid
<input type="checkbox"/> Venipuncture
<input type="checkbox"/> Fit Testing for Particulate Respirators
<input type="checkbox"/> Weapons of Mass Destruction (WMD) Training
<input type="checkbox"/> Chemical, Biological, Radiological, Nuclear & Explosive Training (CBRNE)
<input type="checkbox"/> Other- Please specify: _____
_____ |
|--|--|

Experience: Do you have any of the following skills?

- DC (Doctor of Chiropractic)
- Surgical Technician
- DCM (Doctor of Chiropractic Medicine)
- DDS, DMD (Dentists)
- PharmD (Doctor of Pharmacy)
- DO (Doctor of Osteopathy)
- Pharmacy Assistant
- DPM (Podiatrist)
- Pharmacy Technician
- DVM (Veterinarian)
- Registered/Licensed Pharmacist
- MD (Medical Doctor)
- OD (Optometrist)
- Certified/Licensed Social Worker (CSW, LCSW, other)
- PA (Physicians Assistant)
- Marriage and Family Therapist
- Medical Record and Health Information Technicians
- CRNA (Nurse Anesthetist)
- Mental Health Counselor
- LPN (Licensed Practical Nurse)
- Mental Health Social Worker
- NP (Nurse Practitioner)
- Mental Health Therapist
- Nurse Midwife
- Social Worker (BSW, MSW)
- Nursing Assistant/Patient Care Associate
- Substance Abuse Social Worker
- RN (Registered Nurse)
- Environmental Health Specialist
- Cardiovascular Technologists and Technicians
- Epidemiologist
- Dental Technician
- Health Educator
- Diagnostic Medical Sonographers
- Health Officer
- EMT (Emergency Medical Technician)
- Health Planner
- Funeral Director/Mortician
- Industrial Hygienist
- Informational Technologist (IT)
- Microbiologist
- Laboratory Technician
- Medical and Clinical laboratory Technologists
- Psychologist
- PT/OT (Physical or Occupational Therapist)
- Paramedic
- Radiology Technician
- Respiratory Therapist
- Retired Physician
- Retired Nurse
- Retired Other Health Care Professional
- Student of the Health Professions, please specify:

Expectations of Allentown Volunteer Medical Reserve Corps Professional Health Volunteers

As a volunteer with the Allentown Volunteer Medical Reserve Corps (AVMRC), I will be called upon to assist in the event of a public health emergency. I agree to attend an educational program to explain my role in disaster preparedness; I will be assigned duties based on my level of training and experience. I understand that submitting this application does not guarantee acceptance into AVMRC. The information contained in this application is, to the best of my knowledge, truthful. I agree to serve my fellow citizens to the best of my professional ability.

I agree to the above statement: _____

Signature

Date

Note: Failure to agree to the above statement invalidates the application.

Please complete and return the application. Thank you.

Mail to:

or

Fax to:

Allentown Health Bureau
245 N. 6th Street
Allentown, PA 18102
ATTN: AVMRC

Allentown Health Bureau
Fax: 610-437-8799
ATTN: AVMRC