Clark County Medical Reserve Corps.

Volunteer Registration

Personal Information		
Name:		
Street Address:		
City:	State:	Zip Code:
Primary Phone:		
Secondary Phone:		
Email:	Employer:	

Emergency Contact		
Name:	Relationship:	
Street Address:		
City:	State:	Zip Code:
Primary Phone:		

Skills and Training		
MEDICAL LICENSE OR CERTIFICATION	**OTHER**	**ADDITIONAL TRAINING/EXPIERENCE**
□ Doctor	□ Clergy	□ List any other completed NIMS Training:
Specialty	□ Forklift, Flagger, CDL's	□
□ Physician's Assistant	□ Informational Technologist (IT)	
Specialty	□ Psychological First Aid	
□ Dentist	□ Medical Office Management	
□ Pharmacist	□ Media/Public Relations/PIO	□ Data Entry
□ Nurse: NP CNM RN CNRA LPN CAN	□ Hazmat	□ Office Skills
Type:	□ Weather Spotter	□ HAM Radio Operator
□ Veterinarian	Training	Call Sign : Class:
Specialty		□ Sign Language
□ Paramedic/EMT/Etc.	□ CPR/AED or BCLS or ACLS	O Other Languages
Type:	Expires:	Which:
□ Therapist:	□ NIMS 100	Current License Information
Type:	□ NIMS 200	Type:
□ Mental Health Professional	□ NIMS 300	State Issued:
Type:	□ NIMS 400	Number:
□ Other (Technician, Assistant, Etc.)	□ NIMS 700	Expiration Date:
Type:	□ NIMS 800	

UNIFORM SHIRT SIZE: _____

SEE REVERSE SIDE

Additional Information
Where are you interested in volunteering?   □ Local   □ Statewide   □ Nationally
How frequently would you like to volunteer? □ Regularly   □ Occasionally   □ Emergency Only
Best time to contact: □ Daytime   □ Evenings   □ Weekdays   □ Weekends
Best Form of Contact: □ Phone   □ Email   □ Text
Are you interested in participating in non-disaster community events? □ Yes   □ No
Do you have any special needs or restrictions? If so, please explain:
Please list any other volunteer organizations you participate in:
Do you have any disaster experience? □ Yes   □ No
List any related skills or training that you are authorized to teach:

Please understand, by signing this application you are acknowledging and approving the Clark County Sheriff's Office to make inquiries into your background and criminal history.

My date of birth is: _____   *My Social Security #:* _____
                          mm/dd/yy

I certify that to the best of my knowledge the above information is true and correct.

Signed:_____Date:_____

Once completed fax to: (812) 288-2711 *OR*
scan & Email to: kgriffin@co.clark.in.us
Thank you!

For Office Use Only		
□ Added to Contact List	□ Tier One Training Completed	□ Photo taken for ID
□ License/Certification Approved	□ Tier Two Training Completed	□ Photo ID issue date:_____
□ Required training documented	□ Tier Three Training Completed	
Course Title		
□ ICS-100		
□ NIMS-700	MRC Items Issued:	
□ FEMA IS-22	_____	
□ MRC Orientation	_____	
□ MRC Family Disaster Planning	_____	
□ Terrorism Preparedness	_____	