



Bucks County

Medical Reserve Corps

1282 Almshouse Rd, Doylestown PA 18901

Office: 215-345-3318 Fax: 215-345-3833 Email: HDbcmrc@buckscounty.org

Please complete the information below. * Indicates required information

1. Personal Information

Last Name:* _____ First Name:* _____

Middle Name/Initial:* _____ Title: _____

Date of Birth (mm/dd/yyyy):* _____ Gender:* M F

Street Address:* _____

City:* _____ State:* _____ Zip code:* _____

Home Phone #:* _____ Work Phone #: _____

Cell Phone #:* _____

Primary Email:* _____ Secondary Email: _____

Driver's License/ID State and Number:* _____

2. Professional and Employment Information

Employer: _____ FT: PT: Retired: Student:

Occupation:* _____

Professional License State and Number* (required only for medical professionals):

_____ Active: Retired:

Other License Information: _____

3. Other Response Obligations

Are you a part of any other emergency/disaster response organization which would impact your availability during an emergency response?*

No: Yes: If "Yes", please list: _____

4. Training, Skills, and Education

CPR: Basic: Exp. Date: _____ Advanced: Exp Date: _____

First Aid: Basic: Exp. Date: _____ Advanced: Exp Date: _____

Other Training and Skills (i.e. computer/IT, logistics, disaster response experience, education, etc.):

Do you speak languages other than English?

No: Yes:

If "Yes", please list and indicate level of fluency:

5. Your Interests

If you have a particular capacity in which you would like to volunteer with the BC-MRC please indicate below:

If there any topics which you would like to receive training on, please indicate below:

6. Data Security, Privacy, and Consent

All information is confidential and is for the use of the BC-MRC and Bucks County Department of Health. However, in certain circumstances it may be necessary to share this information with Emergency Management and Health and Human Service agencies.

I give my permission for the BC-MRC to release my information to local, state, and federal emergency management agencies and other Health and Human Service agencies as needed.*

Yes: No: (I understand this may prevent me from volunteering with the BC-MRC)

I verify that the above information is accurate to the best of my knowledge. I do hereby give my local Medical Reserve Corps (BC-MRC) permission to make inquiries concerning licensure, certification, and criminal history.*

Yes: No: (I understand this may prevent me from volunteering with the BC-MRC)

Signature:* _____ Date:* _____

(typing your name is considered the same as your signature)