Print Form Submit by Email

Bucks County Medical Reserve Corps

1282 Almshouse Rd, Doylestown PA 18901

Office: 215-345-3318 Fax: 215-345-3833 Email: HDbcmrc@co.bucks.pa.us

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 #:*_____ Cell Phone Carrier Company:*_____

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)