

Region 4B MEDICAL RESERVE CORPS
CAMBRIDGE PUBLIC HEALTH DEPARTMENT
119 Windsor Street, Cambridge, Massachusetts, 02139
Telephone: (617) 665-3702 Facsimile: (617) 665-3888



VOLUNTEER APPLICATION

Your Local Health Dept. in cooperation with Massachusetts Public Health Region 4b is recruiting a community-based group of volunteers who can serve during a local or regional health emergency and/or assist with local public health needs throughout the year. **Volunteers can choose to serve solely during emergencies, or they may offer their time for both emergencies and non-emergencies, i.e. Flu clinics and health fairs.**

Name:		
Last	First	MI

Address:			
Street	City	State	Zip

Phone:		
Home	Work	Cell
E-mail		Pager

Emergency Contact Information:	
Name	Relationship
Address	Phone

What are you volunteering for?	
Emergencies ONLY: _____	Emergencies AND Non-emergencies (i.e. Flu clinics, health education): _____
Local Volunteer ONLY: _____	BOTH Local and Region 4b* Volunteer: _____

Availability?		
_____ Weekday mornings	_____ Weekday afternoons	_____ Weekday evenings
_____ Weekend mornings	_____ Weekend afternoons	_____ Weekend evenings

*** Are you currently employed or do you volunteer at a hospital or other organization that may need your assistance in an emergency?**
 _____ No _____ Yes, if yes please list agency _____

Volunteer Interests		
_____ Clinical Work	_____ Clergy	_____ Fundraising or grant writing
_____ Public Health	_____ Administration	_____ Newsletter Production
_____ Mental Health/Substance Abuse	_____ Organizing/Volunteer Coordination	_____ Other: _____

Professional / Volunteer Experience:			
Organization	Dates	Position	Supervisor
Address			Telephone
Description of Responsibilities			

Professional / Volunteer Experience (cont.):

Organization	Date	Position	Supervisor
Address			Telephone
Description of Responsibilities			

Licenses & Certifications

Medical License (specify type)	State	Number	Expiration
Nursing License (specify type)	State	Number	Expiration
EMT/Paramedic License (specify type)	State	Number	Expiration
Other License (specify type)	State	Number	Expiration
Certification (list/describe)			Expiration
Certification (list/describe)			Expiration

Have you ever had your professional license suspended or revoked? No Yes (Please attach letter of explanation)

Have you ever been convicted of a felony, or of a misdemeanor that resulted in imprisonment, which was not a first offense?
 No Yes

Language Skills

What is your first language?

Do you have additional language skills? (including sign language) Please circle your capabilities for each

Language	Speak & Understand	Read & Translate	Write
Language	Speak & Understand	Read & Translate	Write

Please list any disaster services training that you have received and/or your prior experience with disaster/crisis response.

CPR Certification	Expiration Date
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Additional Trainings (please describe)

References: Please list three references who are familiar with your qualifications/experience. Do not list relatives.

Name	Phone Number
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Address _____

Name	Phone Number
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Address _____

PLEASE SEND YOUR COMPLETED APPLICATION (AND/OR ANY QUESTIONS) TO:

Patti Brennan
Arlington Board of Health
27 Maple St
Arlington, MA 02476
781-316-3411 * 781-316-3175 (fax)

