

**Defiance County Medical Reserve Corps  
Volunteer Application**

Date of Application \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_  
Street City State Zip

E-Mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_

Occupation \_\_\_\_\_  Full Time  Part Time

Retired  Student

U.S. Citizen? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list areas of Licensure/Certification \_\_\_\_\_

\_\_\_\_\_

Please list areas of expertise, special skills, training, etc. \_\_\_\_\_

\_\_\_\_\_

Please list other volunteer affiliations \_\_\_\_\_

\_\_\_\_\_

Emergency Contact Information

Name \_\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_  
Street City State Zip

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I hereby certify that all the information on page one is accurate and correct and I hereby make application for membership in the Defiance County Medical Reserve Corps. I understand that I am applying for a volunteer position and this is not an application for, or contract of, employment.

I understand that every attempt will be made to reduce risks to volunteer, however, some risks may be present during a public health emergency and I agree to assume my own risk as a volunteer.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**PHOTO PERMISSION:**

Yes, \_\_\_\_\_, I give my permission to be interviewed and/or photographed for publicity purposes. I understand that this information may appear publicly in a newspaper or other advertising media.

**No expiration on this permission unless notified.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**BACKGROUND CHECK:**

The Defiance County Medical Reserve Corps requires that all volunteers should undergo a background check. This is done for safety and security concerns of all citizens of the county and is not meant to be an intrusion. **You may opt out of this without affecting your status as an MRC volunteer.**

\_\_\_\_\_ Yes, I agree to have my background checked.

\_\_\_\_\_ No, I am opting out of having my background checked and it will not affect my MRC status.

**CREDENTIALS VERIFIED:**

I give my permission to have my credentials verified.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**STATE OF OHIO DATA BASE:**

I give my permission to have my name added to the State of Ohio Data Base for liability purposes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return completed application to:** Nathan Hoffer, RN, BSN  
Defiance County Health Department  
1300 East Second Street  
Suite 100  
Defiance, Ohio 43512