



MRC GEM

<http://www.mrcgem.com>

East Metro Health District Medical Reserve Corps, Inc.

A 501(c)(3) nonprofit corporation.

"Be Committed. Be Connected. Be a Volunteer."

5885 Cumming Hwy, Suite 108-151 ~ Sugar Hill, Georgia 30518 ~ 770-614-9916 ~ FAX 770-614-4020

MRC Membership Application

(for entry in SERVGA, Georgia's State Emergency Registry of Volunteers)

Georgia's State Emergency Registry of Volunteers (SERVGA) is a database of people who may wish to help public health personnel respond to an act of terrorism or other public health emergency. It is coordinated with Georgia's public health and Medical Reserve Corps (MRC) volunteer programs. Filling out this form will help connect you with your local MRC unit. MRC GEM serves Gwinnett, Newton, and Rockdale counties. There are other MRC units serving other parts of Georgia.

If you can, please sign up at the <http://www.servga.gov> web site. When filling out the application, be sure to designate "East Metro Health District" as the unit you are joining. If you are unable to sign up online or prefer not to, our volunteers will be happy to assist you in signing up or to enter the data from your paper application form.

If you are already registered with SERVGA, please add "East Metro Health District" as one of your unit affiliations (in your SERVGA profile).

Registering places you under no legal obligation to volunteer. For further questions or information about our MRC unit, please visit our web site at <http://mrcgem.com> or contact us (see above). For more information about the national MRC program, go to <http://www.medicalreservecorps.gov>. For more information about the online volunteer registry, go to <https://www.servga.gov>

Data privacy

Information collected through the registry will be kept private or non-public, except where required by law. Only DHR and its federal, regional, and local partners involved in planning, investigating, or controlling a public health emergency will have access to this information. These partners could include both public health and law enforcement as well as MRC units with whom you affiliate. Providing information to this registry is voluntary. If you decide not to provide this information, however, we may not be able to contact you for emergency volunteer work.

Membership Application for entry in SERVGA

REQUIRED INFORMATION IS MARKED * AND HIGHLIGHTED IN YELLOW.

Section 1: First tell us some information about yourself....

1. Personal information:

*First name:			Middle name:			*Last name:		
*Gender: <input type="radio"/> M <input type="radio"/> F		*Date of birth (mm/dd/yyyy):			*Georgia county you live in:			
*Home address:				*City:			*Zip Code:	
* Drivers License/State ID#			*License State:		*Expiration Date:		Class:	
Primary email address:					Alternate email address:			
For SERVGA login: Desired Username:					Desired password:			
Answer ONE of these five questions for security use:					1. Street where you grew up:			
2. Name of first school:					3. Mother's maiden name:			
4. Father's middle name:					5. Pet's name:			

2. What is the best way to contact you in the event of an emergency?

* 2a. Primary contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager Number:								
2b. Secondary contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager Number:								

***3. Do you have any military service obligations in the event of an emergency?** Yes No

If yes, please explain what they are:

***4. Do you have any other commitments that might pose a conflict in the event of an emergency? If yes, please identify them below:** Yes No

American Red Cross Hospital/clinic (name) : First Responder

Other:

Section 2: Tell us about your work....

5. What is your employment status?

full time part time on call not employed retired student

6. Do you work at more than one location? Yes No **6a. If yes, at how many locations do you work?**

7. In which county or counties do you work?

Please list the counties: _____ County in state bordering Georgia:

8. In what type of setting do you work? (check all that apply)

Health care settings:		Other health-related settings:
<input type="checkbox"/> Clinic	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Assisted living
<input type="checkbox"/> Emergency room	<input type="checkbox"/> Operating room/recovery room	<input type="checkbox"/> Correctional facility
<input type="checkbox"/> Home care/hospice	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Emergency communications center
<input type="checkbox"/> Hospital	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> EMS provider
<input type="checkbox"/> Intensive care	<input type="checkbox"/> Psychiatric/behavioral care/mental health	<input type="checkbox"/> Group home
<input type="checkbox"/> Laboratory/X-ray/other diagnostic procedures	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Public health department
<input type="checkbox"/> Medical/surgical	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Public safety/police department
<input type="checkbox"/> Nursing home		<input type="checkbox"/> School
		<input type="checkbox"/> Other : _____
8a. In what types of activities are you involved on your job? [check all that apply]		
<input type="checkbox"/> Administration	<input type="checkbox"/> Epidemiology	<input type="checkbox"/> Program planning
<input type="checkbox"/> Case management	<input type="checkbox"/> First responder	<input type="checkbox"/> Quality improvement/assurance
<input type="checkbox"/> Clerical	<input type="checkbox"/> Health counseling	<input type="checkbox"/> Research
<input type="checkbox"/> Clinical services	<input type="checkbox"/> Health education or promotion	<input type="checkbox"/> Supervision
<input type="checkbox"/> Disease investigation and control	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Teaching
<input type="checkbox"/> EMS education	<input type="checkbox"/> Insurance/utilization review	<input type="checkbox"/> Telephone triage
<input type="checkbox"/> EMS medical direction/coordination	<input type="checkbox"/> Medical priority dispatching	<input type="checkbox"/> Other:
<input type="checkbox"/> Environmental health	<input type="checkbox"/> Patient care	

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Section 3: In case of a large scale emergency...	
*9. Please list any special limitations you have or other considerations we should know about you:	
*10. Are you willing to travel to help in an emergency?	<input type="radio"/> Locally <input type="radio"/> In state <input type="radio"/> To another state
If yes, for how many days?	<input type="radio"/> Up to 7 <input type="radio"/> Up to 14 <input type="radio"/> Up to 21 <input type="radio"/> Up to 28 <input type="radio"/> Longer
In the event of a declared national emergency, would you consider volunteering to work under the authority of the Federal Government?	<input type="radio"/> Yes <input type="radio"/> No Selecting yes may result in your information being provided to the Federal Government upon its request.

Section 4: Your experience and credentials ...

11. Do you speak any of these foreign languages? [If yes, please check all that apply]	
<input type="checkbox"/> Arabic	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent
<input type="checkbox"/> Khmer (Cambodian)	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent
<input type="checkbox"/> Oromo (Ethiopian)	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent
<input type="checkbox"/> Serbo-Croatian (Bosnian)	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent
<input type="checkbox"/> Spanish	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent
<input type="checkbox"/> Other:	<input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent

11a. Do you know American Sign Language?	<input type="radio"/> Yes <input type="radio"/> No
If yes, what level are you?	<input type="checkbox"/> Limited proficiency <input type="checkbox"/> Intermediate ability <input type="checkbox"/> Fluent

12. Do you have a commercial driver's license?	<input type="radio"/> Yes <input type="radio"/> No	13. Class and endorsement codes:	
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13. Have you had HAZMAT (hazardous materials) training?	<input type="radio"/> Yes <input type="radio"/> No	If yes, training level: <input type="checkbox"/> Awareness <input type="checkbox"/> Operations <input type="checkbox"/> Technician <input type="checkbox"/> Specialist
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14. Have you had basic first aid training?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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15. Have you been trained in CPR (cardiopulmonary resuscitation)?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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16. Have you had incident command training (MIMS, ICSC)?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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17. Do you have training and experience in starting an I.V. (intravenous line)?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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18. Do you have training and experience in giving IV medications?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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19. Do you have training and experience in giving IM (intramuscular) medications?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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20. Do you have training and experience in using equipment to manage a person's airway (for example, a bag-valve mask)?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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21. Have you received formal paramedic training or military medic training?	<input type="radio"/> Yes <input type="radio"/> No	Year of most recent training_____
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*22. Are you currently or have you previously been credentialed by a State of Georgia health professional board? (for example, Georgia Secretary of State)?	<input type="radio"/> Yes <input type="radio"/> No
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If yes, identify the primary license, registration, or certificate you hold/held:

<input type="checkbox"/> Dentist	<input type="checkbox"/> Licensed psychological practitioner	<input type="checkbox"/> Physician
<input type="checkbox"/> Dental assistant	<input type="checkbox"/> Marriage and family therapist:	<input type="checkbox"/> Physician assistant
<input type="checkbox"/> Dental hygienist	<input type="checkbox"/> Licensed <input type="checkbox"/> Licensed associate	<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Respiratory care practitioner
<input type="checkbox"/> EMT - <input type="radio"/> Basic <input type="radio"/> Intermed <input type="radio"/> Paramedic	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Registered nurse
<input type="checkbox"/> First responder	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Social worker: <input type="radio"/> Licensed <input type="radio"/> Lic. graduate
<input type="checkbox"/> Licensed practical nurse	<input type="checkbox"/> Pharmacy technician	<input type="radio"/> Lic. Indepen. <input type="radio"/> Lic. Indepen. clinical
<input type="checkbox"/> Licensed psychologist	<input type="checkbox"/> Physical therapist	<input type="checkbox"/> Other: _____

*23. If you are credentialed by a state board, what is the status of your primary license, registration, or certification? [If you are not, go to question #27]	<input type="checkbox"/> Active <input type="checkbox"/> Inactive Other
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If you currently have a license, please complete the following. This will be used for credentialing purposes.

Note: Those who may be eligible for licensure (for example, students, retired people), but are not currently licensed, may complete this form.

Primary license, certification, or registration #:	Expiration date (mm/dd/yyyy):
If not a West Virginia board, please list the state or province.	State: Canadian province/territory:

***This information is required.**

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If you have more than one license or credential, please list in question #26.

*24. Do you have current or previous experience in a health occupation that is <i>not</i> currently licensed, registered, or certified by the State of Georgia?	<input type="radio"/> Yes <input type="radio"/> No
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25. If yes, please check your primary occupation from the list below, or choose the one that most closely matches your experience (if more than one occupation, please list in question #27):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anesthesiology aide | <input type="checkbox"/> EEG tech | <input type="checkbox"/> Lab technologist or tech | <input type="checkbox"/> Pulmonary function therapist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Electrophysiology tech | <input type="checkbox"/> Medical assistant | <input type="checkbox"/> Radiology tech |
| <input type="checkbox"/> Autopsy assistant | <input type="checkbox"/> Emergency dept tech | <input type="checkbox"/> Medical transcriptionist | <input type="checkbox"/> Radiation coordinator |
| <input type="checkbox"/> Behavioral/mental health worker | <input type="checkbox"/> Emergency med dispatch | <input type="checkbox"/> Multi-spec imaging | <input type="checkbox"/> Radiation technician |
| <input type="checkbox"/> Cardiopulmonary specialist | <input type="checkbox"/> Hand therapist | <input type="checkbox"/> Nursing assistant | <input type="checkbox"/> Radiation operator |
| <input type="checkbox"/> Case management spec | <input type="checkbox"/> Health unit coordinator | <input type="checkbox"/> Nuclear medical tech | <input type="checkbox"/> Radiation therapy specialist |
| <input type="checkbox"/> Chaplain | <input type="checkbox"/> Heart cath specialist | <input type="checkbox"/> Obstetrics tech | <input type="checkbox"/> Surg instrument processing tech |
| <input type="checkbox"/> Clinical/medical transcriptionist | <input type="checkbox"/> Home health aide | <input type="checkbox"/> Occupational therapist/assist | <input type="checkbox"/> Rehab equipment tech |
| <input type="checkbox"/> Community liaison | <input type="checkbox"/> Home service aide | <input type="checkbox"/> Pharmacy tech assistant | <input type="checkbox"/> Surgery tech |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Hospital administrator | <input type="checkbox"/> Physical therapist/assistant | <input type="checkbox"/> Speech/language pathologist |
| <input type="checkbox"/> Cytotechnology tech | <input type="checkbox"/> Intake coordinator | <input type="checkbox"/> Personal care attendant | <input type="checkbox"/> Transport aide |
| <input type="checkbox"/> Discharge planner | <input type="checkbox"/> Intake specialist | <input type="checkbox"/> Psych tech | <input type="checkbox"/> Ultrasound tech |
| <input type="checkbox"/> Drug unit assistant | <input type="checkbox"/> Infection cntrl practitioner | <input type="checkbox"/> Polysomnographic tech | <input type="checkbox"/> Vascular monitoring tech |
| <input type="checkbox"/> Echo tech | <input type="checkbox"/> Kidney dialysis tech | <input type="checkbox"/> Psych assistant | <input type="checkbox"/> X-ray tech |
| <input type="checkbox"/> Echocardiology tech | <input type="checkbox"/> Lab care technician | | |
| <input type="checkbox"/> Other: | | | |

26. Please briefly describe the educational and/or work background you have that is relevant to volunteering in the event of a public health emergency (for example, "I graduated with an associate degree in medical technology in 1988 from the Columbus Technical College. Since graduating, I have worked full-time as a clinical laboratory technician for Emory University Hospital's central lab. I recently began taking classes on a part-time basis to complete a bachelor's degree in medical technology at Emory University.")

ADDITIONAL INFORMATION FOR NURSES, DOCTORS, PHARMACISTS, and DENTISTS:
 If you are a **NURSE**, please continue with **Section 5**.
 If you are a **DOCTOR**, please continue with **Section 6**.
 If you are a **PHARMACIST**, please continue with **Section 7**.
 If you are a **DENTIST**, please continue with **Section 8**.
ALL OTHERS PLEASE CONTINUE WITH SECTION 9.

Section 5: Nurses ONLY

*27. Are you an advanced-practice registered nurse?	<input type="radio"/> Yes <input type="radio"/> No
If yes, what is your classification?	If yes, what is your specialty?
*28. Do you have a specialty certification?	<input type="radio"/> Yes <input type="radio"/> No If yes, indicate below (check all that apply.)
<input type="checkbox"/> Direct patient care	<input type="checkbox"/> Mass immunization
<input type="checkbox"/> Disease investigation	<input type="checkbox"/> Mental health
<input type="checkbox"/> ER	<input type="checkbox"/> Military medic
<input type="checkbox"/> Home health care	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Patient education
<input type="checkbox"/> Mass care	<input type="checkbox"/> Pediatrics
	<input type="checkbox"/> Phlebotomy
	<input type="checkbox"/> Public health nursing
	<input type="checkbox"/> School nursing
	<input type="checkbox"/> Trauma
	<input type="checkbox"/> Triage
	<input type="checkbox"/> Other:

PLEASE CONTINUE WITH SECTION 9.

Section 6: Doctors ONLY

29. Are you an EMS medical director or have other emergency medicine experience?	<input type="radio"/> Yes <input type="radio"/> No
30. Have you provided care in an atypical setting as part of your current or prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)?	<input type="radio"/> Yes <input type="radio"/> No
31. What percentage of your practice is ongoing care/scheduled appointments that could be re-scheduled in case of a large-scale emergency?	
<input type="checkbox"/> 0-10% <input type="checkbox"/> 11-24% <input type="checkbox"/> 25-49% <input type="checkbox"/> 50-74% <input type="checkbox"/> 75-100%	

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***32. What would you consider yourself capable of and agreeable to perform if needed [check all that apply]:**

- | | | |
|--|--|---|
| <input type="checkbox"/> providing acute patient screening | <input type="checkbox"/> providing hospice care | <input type="checkbox"/> performing vaccinations |
| <input type="checkbox"/> providing ambulatory care | <input type="checkbox"/> providing nursing home care | <input type="checkbox"/> screening vaccination candidates |
| <input type="checkbox"/> providing hospital care or care in field hospital | <input type="checkbox"/> providing telephone information | <input type="checkbox"/> providing non-medical assistance (filing, courier, other services) |

***33. What is your primary specialty?**

- | | | |
|--|--|---|
| <input type="checkbox"/> allergy, asthma, immunology | <input type="checkbox"/> gastroenterology | <input type="checkbox"/> pediatrics |
| <input type="checkbox"/> anesthesiology | <input type="checkbox"/> gerontology | <input type="checkbox"/> physical medicine and rehabilitation |
| <input type="checkbox"/> behavioral medicine | <input type="checkbox"/> internal medicine | <input type="checkbox"/> plastic and reconstructive surgery |
| <input type="checkbox"/> cardiology | <input type="checkbox"/> infectious disease medicine | <input type="checkbox"/> psychiatry / child psychiatry |
| <input type="checkbox"/> clinical oncology | <input type="checkbox"/> neurological surgery | <input type="checkbox"/> public health medicine |
| <input type="checkbox"/> clinical endocrinology | <input type="checkbox"/> neurology | <input type="checkbox"/> pulmonary medicine |
| <input type="checkbox"/> colon and rectal surgery | <input type="checkbox"/> obstetrics and gynecology | <input type="checkbox"/> radiology |
| <input type="checkbox"/> critical care medicine | <input type="checkbox"/> occupational/environmental medicine | <input type="checkbox"/> rheumatology |
| <input type="checkbox"/> dermatology | <input type="checkbox"/> oncology | <input type="checkbox"/> sleep medicine |
| <input type="checkbox"/> emergency medicine | <input type="checkbox"/> orthopedic surgery | <input type="checkbox"/> thoracic surgery |
| <input type="checkbox"/> ear, nose, and throat (ENT) | <input type="checkbox"/> ophthalmology | <input type="checkbox"/> vascular surgery |
| <input type="checkbox"/> family practice | <input type="checkbox"/> pathology | <input type="checkbox"/> other: |
| <input type="checkbox"/> forensic medicine | | |

33a. If you have a secondary specialty, please list:

34. Have you had experience in any of the following areas? [check all that apply]

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> administration | <input type="checkbox"/> hospice | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> research |
| <input type="checkbox"/> clinic | <input type="checkbox"/> intensive care | <input type="checkbox"/> other area related to emergency | <input type="checkbox"/> teaching |
| <input type="checkbox"/> counseling | <input type="checkbox"/> medical/surgical | <input type="checkbox"/> psychiatric/behavioral care | <input type="checkbox"/> utilization review |
| <input type="checkbox"/> ER | <input type="checkbox"/> operating room/recovery room | <input type="checkbox"/> pediatrics | <input type="checkbox"/> Other: |

***35. Do you have any special qualifications or interests we should be aware of?** Yes No

If yes, please list:

PLEASE CONTINUE WITH SECTION 9.

Section 7: Pharmacists ONLY

36. Have you provided care in an atypical setting as part of your current or prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)? Yes No

If yes, please describe:

***37. What setting do you currently work in? [mark all that apply]**

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrative office | <input type="checkbox"/> Hospital pharmacy | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Clinic pharmacy | <input type="checkbox"/> Home I.V. therapy | <input type="checkbox"/> Nuclear pharmacy |
| <input type="checkbox"/> Clinical pharmacy | <input type="checkbox"/> HMO clinic pharmacy | <input type="checkbox"/> Nursing home pharmacy |
| <input type="checkbox"/> Community / Retail | <input type="checkbox"/> Industry | <input type="checkbox"/> Pharmacy school/medical school / teaching hospital |
| <input type="checkbox"/> Other | | |

***38. Which activities do you participate in? [mark all that apply to your professional activity]**

- | | | |
|---|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Disease state management | <input type="checkbox"/> Pharmacy benefits management |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Research | <input type="checkbox"/> Teaching |
| <input type="checkbox"/> Dispensing prescriptions | <input type="checkbox"/> Sales | <input type="checkbox"/> Other (specify) |

***39. What would you consider yourself capable of and agreeable to perform if needed? [check all that apply]:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Administering medication | <input type="checkbox"/> Interpreting medication orders | <input type="checkbox"/> Providing telephone information |
| <input type="checkbox"/> Assuring appropriate drug/dose | <input type="checkbox"/> Providing education on treatments | <input type="checkbox"/> Screening vaccination candidates |
| <input type="checkbox"/> Dispensing medication | <input type="checkbox"/> Providing non-medical assistance | <input type="checkbox"/> Vaccinations |

***40. In which specialty area(s), if any, are you certified:**

- | | | | | | |
|--|---|-------------------------------|--------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nutrition support | <input type="checkbox"/> Nuclear pharmacy | <input type="checkbox"/> None | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Pharmacotherapy | <input type="checkbox"/> Other: |
|--|---|-------------------------------|--------------------------------------|--|---------------------------------|

***41. Do you have a subspecialty?** Yes No If yes, name of subspecialty:

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42. Please indicate whether you are certified and/or trained in providing influenza and pneumococcal immunizations.	<input type="radio"/> Yes <input type="radio"/> No
43. Do you have experience in conducting comprehensive patient assessments and in interpreting and adjusting drug therapies?	<input type="radio"/> Yes <input type="radio"/> No
44. Do you have experience in any of the following areas? [check all that apply]	
<input type="checkbox"/> Emergency room <input type="checkbox"/> Intensive care <input type="checkbox"/> Pediatrics <input type="checkbox"/> Primary care medicine <input type="checkbox"/> Psychiatry	

PLEASE CONTINUE WITH SECTION 9.

Section 8: Dentists ONLY

*45. Do you have any specialized training or board certification in the dental field?	<input type="radio"/> Yes <input type="radio"/> No
If "yes", indicate the specialized training or board certification you received. [Fill in all that apply]	
<input type="checkbox"/> Endodontics <input type="checkbox"/> Oral surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Periodontics <input type="checkbox"/> Public health <input type="checkbox"/> Forensic odontology <input type="checkbox"/> Oral pathology <input type="checkbox"/> Pediatric dentistry <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Other:	
*46. What is your primary professional activity? [Fill in only one]	
<input type="checkbox"/> Administration <input type="checkbox"/> Consulting <input type="checkbox"/> Research <input type="checkbox"/> Teaching <input type="checkbox"/> Advanced dental study <input type="checkbox"/> Patient care <input type="checkbox"/> Sales <input type="checkbox"/> Other (specify):	
47. Have you provided care in an atypical setting as part of prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)?	<input type="radio"/> Yes <input type="radio"/> No
*48. Are you on staff at a hospital?	<input type="radio"/> Yes <input type="radio"/> No If yes, please list:
49. What percentage of your practice is ongoing care/scheduled appointments that could be re-scheduled in case of a large-scale emergency?	
<input type="checkbox"/> 0-10% <input type="checkbox"/> 11-24% <input type="checkbox"/> 25-49% <input type="checkbox"/> 50-74% <input type="checkbox"/> 75-100%	
*50. Which activities would you consider yourself capable of and agreeable to perform if needed and training were provided? [check all that apply]	
<input type="checkbox"/> providing acute patient screening and care (clinic setting) <input type="checkbox"/> providing non-medical assistance (filing, courier, other services) <input type="checkbox"/> providing hospital care (or care in field hospital) <input type="checkbox"/> screening vaccination candidates <input type="checkbox"/> providing telephone information <input type="checkbox"/> vaccinations	
51. Have you had recent experience in any of the following areas? [check all that apply]	
<input type="checkbox"/> administration <input type="checkbox"/> ER <input type="checkbox"/> medical/surgical <input type="checkbox"/> research <input type="checkbox"/> clinic <input type="checkbox"/> hospice <input type="checkbox"/> operating room/recovery room <input type="checkbox"/> teaching <input type="checkbox"/> counseling <input type="checkbox"/> intensive care <input type="checkbox"/> pediatrics <input type="checkbox"/> utilization review <input type="checkbox"/> Other area related to emergency care:	

Section 9: (ALL applicants complete)

52. How did you hear about the opportunity to volunteer in a health emergency?

<input type="checkbox"/> brochure/flyer	<input type="checkbox"/> mailing	<input type="checkbox"/> TV/radio	<input type="checkbox"/> professional organization	<input type="checkbox"/> article/publication
<input type="checkbox"/> internet	<input type="checkbox"/> presentation	<input type="checkbox"/> friend/acquaintance	<input type="checkbox"/> other:	

53. Emergency contact:

*First name:	*Last name:	*Relationship
*Primary contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager	*Number:
Secondary contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager	Number:

54. Acknowledgment

I hereby certify that all statements made in this application are true and I agree and understand that any misstatement of material facts may cause forfeiture of my eligibility for enrollment as a health professional reserve volunteer. I also understand that falsification or omission of information may result in my removal from eligibility as a volunteer. I understand that submitting this application does not guarantee selection for placement. I understand that the information from this application may be shared with federal, state, regional or local partners in planning for emergency preparedness and with those agencies where I will be placed as a volunteer. I authorize my Medical Reserve Corps officials to check any information regarding my application and information about criminal background and agree to submit a separate form indicating authorization to release this information. I understand that I have the right to withdraw my application or discontinue my enrollment as a volunteer at any time with written notification to my MRC office.

*Signature		*Date	
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***This information is required.**