

Delaware County Medical Reserve Corps (MRC)
Volunteer Information

Name: _____

Include my name in the Local Medical Reserve Corps: Yes No

Please provide your License Number _____

Home	Office
<i>Email:</i>	<i>Email:</i>
<i>Mailing Address:</i>	<i>Mailing Address:</i>
<i>City, State, Zip:</i>	<i>City, State, Zip:</i>
Contact Numbers	Contact Numbers
<i>Phone:</i>	<i>Phone:</i>
<i>Cell:</i>	<i>Cell:</i>
<i>Pager:</i>	<i>Pager:</i>
<i>Fax :</i>	<i>Fax :</i>

Please Check your profession:

<input type="checkbox"/> <i>Physician</i>	<input type="checkbox"/> <i>LPN</i>
<input type="checkbox"/> <i>Pharmacist</i>	<input type="checkbox"/> <i>Mental Health Counselor</i>
<input type="checkbox"/> <i>Social Worker</i>	<input type="checkbox"/> <i>Veterinarians</i>
<input type="checkbox"/> <i>Registered Sanitarian</i>	<input type="checkbox"/> <i>Morticians</i>
<input type="checkbox"/> <i>Registered Nurse</i>	<input type="checkbox"/> <i>Other (Please specify)</i>

Sample activities: medical treatment and triage, vaccinator, medical screener, mental health consultant, health educator, clinic support, field sample collection & site visits, disease investigation, etc.

Indicate any medical specialty/training:

<i>Specialty 1:</i>
<i>Specialty 2:</i>
<i>Specialty 3:</i>

Comments or Suggestions:

Please send this form to:

Lux Phatak, Delaware General Health District, P. O. Box 570, Delaware, OH 43015-0570

Or

Email to: lphatak@delawarehealth.org

Or

Fax to: (740) 203-2003