

VOLUNTEER APPLICATION

Application Date: _____

PERSONAL INFORMATION (Information will only be used for Health Reserve Corps purposes)

Last Name: _____ First Name: _____ Middle Initial: _____

Employer: _____ Phone: _____

Current Work Position: _____

Work Address: _____ Zip Code: _____

Work E-mail: _____

Home Address: _____ Zip Code: _____

Home E-mail: _____ Phone: _____

Mobile Phone: _____ Pager: _____

Drivers License Number: _____ State: _____ Restrictions: _____

Where do you prefer to receive phone calls? Day time home work mobile Evening home work mobile

Where do you prefer to receive e-mails? home work

Where do you prefer to receive mail? home work

Local Emergency Contact: _____ Phone: _____

Out of Area Emergency Contact: _____ Phone: _____

Previous emergency training: _____

Languages spoken (other than English): _____

Other special skills: _____

PROFESSION

Please identify your area of training and expertise:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Certified Nurse Assistant | <input type="checkbox"/> Lab Technician | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Radiology Technician |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Mental Health Provider | <input type="checkbox"/> Pharmacy Technician | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Emergency Medical Tech. | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Paramedic | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Veterinarian |

LICENSURE

Licensing Board: _____ State: _____

Highest level of Licensure/Certification #: _____ Issue Date: _____ Exp. Date: _____

Clinical Specialty/Area of Practice: _____

Areas of Special Professional Expertise/Interest: _____

For physicians, physician assistants and nurse practitioners

Current credentialing through: _____
Name of institution(s)

Currently, I have privileges to practice at: _____
Name of institution(s)

**Please send a current copy of your professional license to: Multnomah County Health Department, Attn: Health Reserve Corps, 426 SW Stark, 8th floor, Portland, OR 97204
(Note: not required for nurses and physicians – information available online though Board database)**

MEDICAL LIABILITY

In the event you are activated to respond to a local emergency, as a volunteer of the Multnomah County Health Department, Health Reserve Corps, you are protected by the provisions of the Oregon Tort Claims Act. The County will defend, save harmless, and indemnify you from malpractice claims and liability arising from your volunteer service as long as you limit the scope of your duties to assigned tasks and perform your work in good faith, in a manner that is not reckless or with intent to harm others **and report any claims arising from your volunteer work to the Multnomah County Health Department.** This protection is stated in the Oregon Tort Claims Act, ORS 30.260 - 30.300 and MCHD Administrative Guidelines 304(1) and 502(1).

By submitting this application for membership in the Multnomah County Health Reserve Corps, I understand and agree to the following:

- I am willing to volunteer for the purpose of providing healthcare services as directed by public health authorities in the event of an emergency.
- I am willing to be notified and activated when additional healthcare providers are needed to support the response to an emergency. If I am unable to respond it will not affect my standing as a volunteer.
- In a local emergency, I will be covered for medical liability protection under the Oregon Tort Claims Act, and will also be covered by County workers compensation for injuries suffered in volunteer service.
- I will participate in the required orientation and basic training.
- I will notify Multnomah County HRC if my contact information changes.
- I will notify Multnomah County HRC if my Oregon license is suspended, revoked or not renewed.

All information provided in this application is true to the best of my knowledge:

Signature

Date

PLEASE SUBMIT APPLICATION AND COPY OF LICENSE TO:

Mail: Zumana Rios, Program Staff
Health Reserve Corps
426 SW Stark, 8th floor
Portland, OR 97204

Fax: Attn: Zumana Rios (503-988-3676)

HRC Program Use (080304)

Application received: _____
Application reviewed: _____
Database profile created: _____
Identification issued: _____