

Northeast Ohio Medical Reserve Corps, Inc

Membership Application



Please print clearly.

Personal Contact Information

Last Name _____ First Name _____ MI _____ Dr. Mrs. Mr. Ms.
(Circle one above)

Maiden name/other names used: _____ OH Driver's License # _____ Date of Birth: _____

Home Address: Street _____ Apt. # _____

County _____ City _____ State _____ Zip Code _____

Phone # () _____ ALT Phone # () _____

E-mail Address _____

Have you ever been convicted of a felony? **Y** **N** Misdemeanor? (other than traffic violations) **Y** **N**
If YES, please explain:

emergency contact:

Name: _____ Relationship: _____

Phone number: _____

Do you have any personal health issues that would impact your ability to volunteer? **Yes** **No**
(For example, allergies, medication issues, disabilities, special needs, or being treated for a medical condition) If yes, please either list here or speak personally with the MRC Coordinator.

Work Contact Information

Occupation _____ (check)

Full Time Part Time Retired Student

License (Professionals with a current license or certification in any health or mental health field)

Type of Medical License (If you have one)	State Issued	Expiration Date
---	--------------	-----------------

1. _____

2. _____

3. _____

Certifications & Training

(Check any that apply)

Certifications

Most Recent Date

Certifying Agency

CPR

First Aid

Disaster Training

Other Certifications

Amateur Radio Callsign: _____

License Class: _____

Other skills that may be beneficial to the Northeast Ohio Medical Reserve Corps?

How did you learn about the Northeast Ohio Medical Reserve Corps?

I hereby certify that all of the information submitted on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered my application may be rejected and if I am a member and any of these items are later discovered my membership may be terminated at any time.

In consideration of my membership, I agree to conform to all the rules, regulations, standard operating procedures and guidelines of the Northeast Ohio Medical Reserve Corps and agree that my membership can be terminated without notice at any time at either my or the Northeast Ohio Medical Reserve Corps option. I further understand that the terms and conditions of membership may be changed without or without cause or notice at any time by the Northeast Ohio Medical Reserve Corps Board of Trustees.

I further authorize you (should the need arise) to investigate my personal and or criminal history, as you deem necessary.

Signature of applicant

Please return application form to:
Email To: neomi216@gmail.com

Date

Approved _____

Denied _____

Date & Initials _____

- Membership Classification:**
- Full Member
 - Associate Member
 - Communications Member
 - Honorary Member
 - Auxiliary Member
 - Volunteer