



# Rensselaer County Medical Reserve Corps Volunteer Registration



Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Last First Middle  
City: Zip:

Email: \_\_\_\_\_ Ph: H (\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone (day): \_\_\_\_\_ (eve): \_\_\_\_\_

**Licenses (Professionals with a current license or certification in any Health or Mental Health field)**

|                                       |                                  |                        |
|---------------------------------------|----------------------------------|------------------------|
| <b>List all Professional Licenses</b> | <b>State Issued &amp; Number</b> | <b>Expiration Date</b> |
|---------------------------------------|----------------------------------|------------------------|

---



---

Do you have prescriptive authority?  Yes  No

Current Certifications: BLS: y/n ACLS: y/n CPR: y/n Other: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Areas of Nursing/Medicine in which you have experience and training:

---



---

**Please list any areas of special interests or skills you may have:**

---

Are you part of an emergency/disaster plan with any other organization? (Such as the Red Cross, etc.)  
 Yes  No  If yes, please list \_\_\_\_\_

Do you have any personal health issues that would impact your ability to volunteer, such as  
 heart condition, physical impairment, asthma, allergies etc? Yes  No

If yes, please specify: \_\_\_\_\_

Have you ever been convicted of a felony? Yes  No

I hereby certify that all statements contained on this application are true to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return to:**

Sue Jones, MRC -Coordinator  
 Rensselaer County Health Department  
 1600-7<sup>th</sup> Avenue  
 Troy, NY 12180      PHONE: 518-270-2633      [sjones@rensco.com](mailto:sjones@rensco.com)