TOWN OF CARLISLE
VOLUNTEER APPLICATION

Please print or type

Name		
Street Address (Mailing)		
City	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**
Email		**Employer**

Type: Medical Professional:

- ❑ **Doctor**
  Specialty_____
- ❑ **Nurse**
- ❑ **Dentist**
- ❑ **Pharmacist**
- ❑ **Psychiatrist**
- ❑ **Veterinarian**

- ❑ **Mental Health**
- ❑ **Social Worker**
- ❑ **EMT**
- ❑ **Non Medical**
  Skills _____
- ❑ **Other_____**
  _____

Emergency Contact Information:

Name:

Address:

Home #:
Cell #:

License or Certificate/Registration Number:

Languages:

Drivers License #:

State License Held:

Expiration Date:

Level of Participation Desired: I prefer to be:

- ❑ **ACTIVE** — **Receive notifications of ALL training opportunities, training drills & exercises, emergency events, as well as non-emergency volunteer opportunities**
- ❑ **LIMITED** — **Receive only notification of training drills & exercises and all emergency events**

Volunteer Interests: Check all that apply:

Administration___ Public Safety ___ Phone Bank___ Steering Committee___ Clinical___ Fundraising___ Database___
Food Service ___ Volunteer Coordination___ Behavioral Health___ Deliveries___ Clerical Help___

A Criminal and Sexual Background Check is required of all volunteers:
I do hereby give Region 4A Medical Reserve Corps permission to release personal information with local, state and federal emergency management agencies and other Health and Human Service agencies as needed.

Date of Birth _____/_____/_____ Social Security #_____

Signature _____ Date_____/_____/_____

Location Preference for Responding: Check all that apply

Your town only	☐	Region 4A	☐	New England	☐	Anywhere in the US	☐
Surrounding Towns	☐	State	☐	East Coast	☐	Anywhere in the world	☐

Signature	**Date**

Privacy Act Statement

This information is requested by Region 4A Medical Reserve Corps and is for the purpose of organizing volunteers and staff to respond to public health emergencies. It will not be utilized or released for any other purpose without your express written permission unless required by law and all information will be kept in a secure manner.

Carlisle Board of Health Call # 978-369-0283
Email lfantasia@carlisle.mec.edu; or mail to:
Carlisle Board of Health, 66 Westford Street, Carlisle, MA 01741