



McHenry County Department of Health



# McHenry County Medical Reserve Corps Application Form

\*Last Name \_\_\_\_\_ \* Full/Legal First Name \_\_\_\_\_ \*Middle Initial \_\_\_\_\_

Title \_\_\_\_\_ (Ms/Mrs/Mr/Dr/etc)      Nickname \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_      Zip Code \_\_\_\_\_

E-Mail \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Preferred method(s) of contact in addition to email:      Home Phone \_\_\_\_\_      Cell Phone \_\_\_\_\_

### Additional Information Required for Background Check:

\*Driver's License Number \_\_\_\_\_      \*Driver's License State \_\_\_\_\_

\*Date of Birth (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_      \*Race \_\_\_\_\_

\_\_\_\_\_

### In Case of Emergency

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

All lines above marked with an asterisk must be completed for background check

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## Medical History

Please check if you now have or have ever had any physical restriction, disease, or condition, including the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Back Issues     | <input type="checkbox"/> Dietary Restrictions | <input type="checkbox"/> Hemophilia         |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hearing Disorder     | <input type="checkbox"/> Vision Disorder    |

If you have checked any of the above, please explain any limitations to ensure appropriate task/shift assignments. If you have restrictions not listed above, please use below space to describe.


# Medical Profession (if applicable)

Profession \_\_\_\_\_ Are you actively practicing? \_\_\_\_\_  
(EX: MD, RN, LPN, CNA, DDS, Pharm, EMT)

License or Certification Number \_\_\_\_\_ State \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Which setting best describes your current or most recent work experience?

- Presently not working  Hospital  Clinics  Enrolled in School  Public Health  EMS  Retired  School  
 Private Practice \_\_\_\_\_ Other \_\_\_\_\_

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## Employment

### Current Employment

Present Employer \_\_\_\_\_

Supervisor \_\_\_\_\_

Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Position/Title \_\_\_\_\_

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## Areas of Experience

Language(s) in which you are fluent: \_\_\_\_\_

Please check if you have certification, training or experience in any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> CERT Training                  | <input type="checkbox"/> Incident Command/Management |
| <input type="checkbox"/> Clerical                       | <input type="checkbox"/> Infection Control           |
| <input type="checkbox"/> Computer/IT                    | <input type="checkbox"/> IMERT/INVENT Training       |
| <input type="checkbox"/> CPR                            | <input type="checkbox"/> Leadership/Supervisor       |
| <input type="checkbox"/> Crisis Intervention/Management | <input type="checkbox"/> Logistics                   |
| <input type="checkbox"/> Disaster Life Support          | <input type="checkbox"/> Risk Communication          |
| <input type="checkbox"/> Emergency Medical Training     | <input type="checkbox"/> Severe Weather Spotting     |
| <input type="checkbox"/> First Aid                      | <input type="checkbox"/> Vaccination                 |
| <input type="checkbox"/> First Responder Training       |  |
| <input type="checkbox"/> HAZ Mat Training               |  |

**Other** skills or information regarding life experience, trainings, or areas of interest that you would like to share:


## References

Please list two **non-relative** professional references.

#1

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

#2

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

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How did you learn about the McHenry County Medical Reserve Corps?

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## Authorization

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for volunteer placement as may be necessary in arriving at a placement decision.

McHenry County Department of Health has my permission to contact the above references.

I understand that by signing below, I also give permission for McHenry County Department of Health to conduct a criminal background check.

I understand that my name and contact information will be put into a Secured Database to be managed by the McHenry County Department of Health.

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

Please return application to: **Chrissy Huelsman -Medical Reserve Corps**  
**McHenry County Department of Health**  
**2200 N Seminary Ave, Building A**  
**Woodstock, IL 60098**