

# Volunteer Information Form - Medical

please print

Name: \_\_\_\_\_ SSN \_\_\_\_\_  
last first  
address \_\_\_\_\_  
street city state Zip  
phone: \_\_\_\_\_  
home cell email

emergency contact: \_\_\_\_\_  
name phone relationship

Profession \_\_\_\_\_ specialty \_\_\_\_\_ ohio license # \_\_\_\_\_

health problems NO YES explain: \_\_\_\_\_  
special needs? \_\_\_\_\_  
\_\_\_\_\_

disaster training BDLS ADLS MINS ICS ARC OTHER

SKILLS AND TRAINING	
_____	VRC use
_____	ID check _____
_____	what? _____
_____	Interview _____
_____	by? _____
_____	safety _____
_____	credentials _____
_____	transport/exit _____
_____	_____

Will you be available for additional shifts beside today