



Please fill out this form to join the Public Health Reserve Corps. Your information will be entered into the program database and will not be shared without your consent.

**Primary Contact Information**

First Name:		Last Name:		Maiden Name:		Middle Initial:	
DOB:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F			Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address:		City:		State: NC		Zip:	
Home Phone:		Cell Phone:		Provider:		Work Phone: Ext.:	
Pager:				E-mail:			
Credentials/ Education (degrees held):							

**Emergency Contact Information**

<b>Primary Contact:</b>		Relation:	
Address:		City:	
Phone:		Cell Phone:	
		State:	
		Zip:	
		Pager:	

<b>Alternate Contact:</b>		Relation:	
Address:		City:	
Phone:		Cell Phone:	
		State:	
		Zip:	
		Pager:	

**Profession / Education**

Are you a High School Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what school do you attend? Number of Community Service Hours Needed:	
Are you a UNC School of Nursing employee?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a hospital employee?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a UNC Student Health employee?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Job Title:		Specialty:	
Employer Address:		Employer:	
		City:	
		State: NC	
		Zip Code:	
Work Status: <input type="checkbox"/> Student <input type="checkbox"/> FT Employee <input type="checkbox"/> PT Employee <input type="checkbox"/> Retired <input type="checkbox"/> Not Practicing			

**Immunization History**

Volunteers are required to provide records documenting recent TB skin test (within last 12 months), Measles, Mumps, and Rubella vaccination or titer, Varicella (Chicken Pox) vaccination, titer, or disease and Hepatitis B vaccination series for Health Care Professionals. **Please note:** records can be sent with registration form or sent separately.

**Professional License (If Applicable)**

License Type:	State:	Lic. #:	Expires:
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**Current or Most Recent Practice Setting:**

<input type="checkbox"/> Clinic Office / Administrative Student	<input type="checkbox"/> Nursing Home / LTC Facility Other:
<input type="checkbox"/> Community Center	<input type="checkbox"/> Public/Community Health
<input type="checkbox"/> Government / Business	<input type="checkbox"/> Private Practice
<input type="checkbox"/> Health Department	<input type="checkbox"/> Research
<input type="checkbox"/> Hospital	<input type="checkbox"/> Teaching / Academia
<input type="checkbox"/> Maternal/Child Health	<input type="checkbox"/> Sales/Marketing
	<input type="checkbox"/> Other:

**Volunteer Interests**

- I would like to volunteer for **Ongoing Public Health Programs** only.
- I would like to volunteer for **Public Health Emergency** preparedness efforts only.
- I would like to volunteer for **Public Health Programs** and **Public Health Emergency Preparedness** efforts.

**Special Interests**

- |  |  |
|--|--|
| <input type="checkbox"/> Disaster / Emergency Response | <input type="checkbox"/> Mass Prophylaxis/Immunization |
| <input type="checkbox"/> Clinical Services             | <input type="checkbox"/> Special Needs Shelters        |
| <input type="checkbox"/> Community Health Education    | <input type="checkbox"/> Well-Child Immunizations      |
| <input type="checkbox"/> Communicable Disease Mgmt.    | <input type="checkbox"/> Program Building /Task Forces |
| <input type="checkbox"/> General Needs Shelters        | <input type="checkbox"/> Other                         |

**Availability**

Weekday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Duration</b>	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs
<b>Time of Day</b>	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible

**Other Info:**

Other volunteer commitments:	Approx. hours dedicated to other volunteer activities:
Special skills (languages, computer, certifications, etc.):	List any special needs or work restrictions:
How did you hear about the Public Health Reserve Corps?	Other information we should know about you:

**Photography Use Agreement:** "I understand that the Orange County Public Health Reserve Corps uses program activity photos for publicity and display purposes that may easily identify some individuals. I give the Orange County Public Health Reserve Corps consent to use program activity photos for these purposes."

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

*If completed electronically, print and sign agreement.*

**Thank you for Registering!**  
**Return form to:**  
 Orange County Health Department  
 Attn: Amanda Bartolomeo  
 300 W. Tryon St.  
 Hillsborough, NC 27278  
 Phone: 919-245-2388  
 Fax: 919-644-3380