



**Nebraska Medical Reserve Corps**

**Application**



**Nebraska**

*Volunteers Building Strong, Healthy,  
and Prepared Communities*

For more information: [www.nemedicalresponse.com](http://www.nemedicalresponse.com)

**Are you registering to be a volunteer with the Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)?**  Yes  No

**Are you registering to be a volunteer with your local Medical Reserve Corps (MRC)?**  Yes  No  
If yes, please check all MRC's you wish to be a registered volunteer with.

Central Nebraska Medical Reserve Corps  Yes  
Serving Adams, Blaine, Buffalo, Clay, Custer, Dawson, Franklin, Garfield, Gosper, Greeley, Hall, Hamilton, Howard, Harlan, Loup, Kearney, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster and Wheeler Counties.

Panhandle Medical Reserve Corps  Yes  
Serving Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan and Sioux Counties.

RROMRS Medical Reserve Corps  Yes  
Serving Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Antelope, Boone, Nance, Platte, Colfax, Madison, Pierce, Cedar, Dixon, Wayne, Stanton, Cuming, Burt, Thurston and Dakota Counties.

Nebraska/Western Iowa Medical Reserve Corps  Yes  
Serving Douglas, Sarpy, Washington, Dodge, Saunders, Harrison and Pottawattamie Counties.

Southeast Nebraska Medical Reserve Corps  Yes  
Serving Butler, Cass, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Seward, Thayer and York Counties.

West Central Nebraska Medical Reserve Corps  Yes  
Serving Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dundy, Hitchcock, Red Willow and Furnas Counties.

**Are you registering to be a volunteer for both the ESAR-VHP and MRC programs?**  Yes  No

Your registration form will be sent to the program(s) for which you are registering.

**SECTION I** (Please Print)**Identity Information – Legal Name**

Last Name:	First Name:	Middle Name:	Suffix:
SSN Last 4 Numbers:	Birth Date: (month/date/year)	Occupation:	

**Contact Information**

Home Street Address:	City:	State:
County:	Zip Code:	
Home Phone:	Work Phone:	Pager Number:
Primary E-mail Address:	Cellular Phone:	

**Preferred Method of Contact During a Declared Emergency**

(Please indicate preference from 1 to 5. 1=most preferred.)

Please note if you do not have one of the following methods of contact place a 0 in the field.

\_\_\_ Home Phone    \_\_\_ Work Phone    \_\_\_ Cellular Phone    \_\_\_ Pager    \_\_\_ E-mail

**Emergency Contact Information**

Name of Relative/Friend/Acquaintance To Contact In Case of Emergency:		
Emergency Contact Relationship:	Emergency Contact Home Phone:	Emergency Contact Work Phone:

**Deployment Preferences**

Are you willing to work under the auspices of the Federal Government during a declared national public health emergency?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Area and availability after notification (select all that apply)	One Hour	One Day	Greater than One Day		
Local	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Intrastate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
National	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Time in days willing to be deployed (select all that apply)	0-10	11-30	31-90	91-180	>180
Local	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrastate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
National	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Language Skills**

Do you speak any language other than English?  Yes  No

If yes, what language(s) and level of fluency:

\_\_\_\_\_  Basic  Conversational  Fluent

\_\_\_\_\_  Basic  Conversational  Fluent

\_\_\_\_\_  Basic  Conversational  Fluent

**Disaster Training Skills**

Certifications	Most Recent Date Completed	Certifying Agency
CPR		
First Aid		
Disaster Training		
CERT		
ICS		
NIMS		
BDLS		
ADLS		
Psychological First Aid		
Other		

**SECTION II** *(Please Print)*

**State License**

Is the name on your license the same as your legal name, provided above?

Yes  No (If No, complete the name questions)

Last Name:	First Name:	Middle Name:	Suffix:
License Number:	License State:	License Expiration Date:	
Are there any adverse actions or restrictions associated with your license?			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Certification/Registration**

Is the name on your certification the same as your legal name, provided above?

 Yes  No (If No, complete the name questions.)

Last Name:	First Name:	Middle Name:	Suffix:
Certifying Institution:		Certification Type:	
Certification Number:		Certification Expiration Date:	

**Primary Specialty/Subspecialty Certification**

Is the name on your certification the same as your legal name, provided above?

 Yes  No (If No, complete the name questions.)

Last Name:	First Name:	Middle Name:	Suffix:
Primary Specialty:		Specialty Issuing Organization:	
Specialty Certification Number:		Specialty Certification Expiration Date:	
Subspecialty:		Subspecialty Issuing Organization:	
Subspecialty Certification Number:		Subspecialty Certification Expiration Date:	

**Specialty Certification**

Is the name on your certification the same as your legal name, provided above?

 Yes  No (If No, complete the name questions.)

Last Name:	First Name:	Middle Name:	Suffix:
Specialty:		Specialty Issuing Organization:	
Specialty Certification Number:		Specialty Certification Expiration Date:	

**Skill by Practical Experience Without Formal Training**

Specialty Based on Experience:	Number of Years Practicing Specialty:
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**Primary Hospital**

Are you employed by a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answer yes to either question, please complete this section (Primary Hospital) and skip the Clinic Practice questions.		
Do you have privileges at a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hospital Name:	Hospital City:	Hospital County:	Hospital State:
Hospital Specialty:	Additional Hospital Specialty:		

### Clinic Practice

(Outpatient facility or other non-hospital setting)

Are you a private practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete peer questions If No, please skip peer questions.)			
Practicing Specialty:		Clinic Name:	
Clinic City:		Clinic County:	Clinic State:
Supervisor's Name:		Supervisor Phone Number:	Supervisor E-mail Address:
<b>Peer Questions</b>		Peer Phone Number:	
Professional Peer's Name:			
Peer E-mail Address:		Peer City:	Peer State:

### DEA Registration

Is the name on your certification the same as your legal name, provided above?

Yes    No (If No, complete the name questions)

Last Name:	First Name:	Middle Name:	Suffix:
DEA Registration Number:		DEA Registration Expiration Date:	

### Consents and Pledges

Yes    No   **Felony Conviction**

Have you ever been convicted of a felony?

Yes    No   **Information Use**

My submission of this form will constitute my consent to the collection, maintenance and use of this information and the transfer of this information across the Internet to processing and storage facilities supporting this system.

Yes    No   **Information Pledge**

I pledge to provide only the correct information when completing this registration process. I also give consent to the State of Nebraska and its designated agents to collect, use and maintain any information collected through this process.

\_\_\_\_\_  
Date

Yes    No   **Background Check**

I give consent to the State of Nebraska and its designated agents to perform reference and background checks based on the information provided.

\_\_\_\_\_  
Date

Yes  No **Electronic Information**

I agree to receive required administrative and legal notices such as this electronically.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I hereby certify that all the information shown above is accurate and correct and I hereby make application for member in the Central Nebraska Medical Reserve Corps. I understand that I am applying for a volunteer position and that this is not an application for, or contract of, employment.

I understand that every attempt will be made to reduce risks to volunteers, however some risks may be present during a public health emergency and I agree to assume my own risk as a volunteer.

I do hereby give the Central Nebraska Medical Reserve Corps permission to inquire into my educational background, references, driving record, police records, employment and my volunteer history. I further give permission to the holder of any such records to release same to the Central Nebraska Medical Reserve Corps or its sponsoring agencies. I understand that the Central Nebraska Medical Reserve Corps will only use this information as part of its verification of my volunteer application and periodically for evaluation purposes. I do hereby hold the Central Nebraska Medical Reserve Corp harmless from any liability, whether civil or criminal, that may arise as a result of their release of this information about me. I further hold harmless any individual, agency, business or corporation that provides information or documents to the Central Nebraska Medical Reserve Corp.

A Photocopy of this release form will be valid as an original thereof even though the said photocopy does not contain an original writing of my signature.

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date Requested \_\_\_\_\_ By \_\_\_\_\_ Returned \_\_\_\_\_

Interview Set up \_\_\_\_\_ By \_\_\_\_\_

Interview Date and Time \_\_\_\_\_ By \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

—

Position Interested In \_\_\_\_\_

Verified Background \_\_\_\_\_

License \_\_\_\_\_ References \_\_\_\_\_

Accepted for Volunteer Position

**Date Placed** \_\_\_\_\_

Not placed \_\_\_\_\_ No position \_\_\_\_\_ Background \_\_\_\_\_ License \_\_\_\_\_ Other \_\_\_\_\_

Entry Date \_\_\_\_\_ By \_\_\_\_\_

**RETURNED COMPLETED APPLICATION TO:**

Central Nebraska Medical Reserve Corps Phone: 402.461.2360  
C/O – Shelly Boden Fax: 402.461.2367

**centralnebraskamrc@gmail.com**

1313 N. Hastings  
Hastings NE 68901