



Volunteers Building Strong, Healthy, and Prepared Communities



VOLUNTEER APPLICATION NATICK MEDICAL RESERVE CORPS

Please print or type CLEARLY

Name		Date of Birth (Required: mm/dd/yy) ____/____/____	
Street Address (Mailing)		Last 6 digits of Social Security Number(Required) ____-____-____	
City	State	Zip	
Home Phone	Work Phone	Cell Phone	
E-Mail		Employer	
Occupation Type (Medical): <input type="checkbox"/> Physician Specialty: _____ <input type="checkbox"/> RN/LPN/ APRN (circle) <input type="checkbox"/> Dentist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Veterinarian <input type="checkbox"/> EMT / Paramedic (Circle) <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____ _____	Occupation Type: <input type="checkbox"/> Non Medical Describe: _____ _____ _____	Volunteer Interests. Check all that apply: <input type="checkbox"/> Executive Committee <input type="checkbox"/> Clinical <input type="checkbox"/> Administration <input type="checkbox"/> Clerical <input type="checkbox"/> Database <input type="checkbox"/> Public Safety <input type="checkbox"/> Fundraising <input type="checkbox"/> Publicity <input type="checkbox"/> Newsletter <input type="checkbox"/> Volunteer Coordination	
License or Certificate/Registration Number: State License Held: _____ Expiration Date: _____		Languages: _____	Drivers License #: _____
<p>A Criminal Offender and Sexual Offender Background Check is required of all volunteers (CORI/SORI). <u>Please complete the CORI Request Form on the back of this application.</u></p> <p>I hereby state that the above information is accurate to the best of my ability, and hereby give Region 4A/ Natick 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.</p> <p>Signature X _____ Date _____</p>			

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.

Mail to: Leila Mercer, RN, Public Health Nurse Natick Health Department 13 E Central St, Natick, MA 01760	Email: lmercer@natickma.org Phone: 508-647-6460
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The Commonwealth of Massachusetts
 Department of Public Health
 Emergency Preparedness Bureau
 250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
 GOVERNOR

JOHN W. POLANOWICZ
 SECRETARY

CHERYL BARTLETT
 ACTING COMMISSIONER



CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

MA Responds is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS (Department of Criminal Justice Information Services). I hereby acknowledge and provide permission to MA Responds staff to submit a CORI check with my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing MA Responds staff with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: MA Responds may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, MA Responds staff must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE _____

DATE _____

VOLUNTEER UNIT _____

Once received by MA Responds this Acknowledgement Form will be used to run a CORI and will then be kept secure in a locked file cabinet at MDPH's Emergency Preparedness Bureau for a minimum of one year.

MAIL FORM TO:
 Department of Public Health
 Emergency Preparedness Bureau
 250 Washington Street, 1ST Floor Boston, MA 02108
 ATTN: MA Responds

SUBJECT INFORMATION (PLEASE PRINT): (an asterisk (*) denotes a required field)

***Last Name** ***First Name** Middle Name Suffix

Maiden Name (or other name(s) by which you have been known, if applicable)

***Date of Birth** ***Place of Birth**

***Last Six (6) Digits of Your Social Security Number** _____ - _____ *(required for CORI)*

Sex: _____ Height: ___ ft. ___ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

 Mother's Full Maiden Name Father's Full Name

Current and Former Addresses:

 Street Number & Name City/Town State Zip

 Street Number & Name City/Town State Zip

(For requestor's use only)

The above information was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY:

 Name of Verifying Employee (Please Print)

 Signature of Verifying Employee