



CENTRAL GEORGIA MEDICAL RESERVE CORPS



Georgia Department of Public Health

North Central Health District

www.northcentralhealthdistrict.org/mrc

201 Second Street Macon, GA 31201

Office: (478) 751-3029

Fax: (478) 751-4575

MRC Membership Application

(for entry in SERVGA, Georgia's State Emergency Registry of Volunteers)

Georgia's State Emergency Registry of Volunteers (SERVGA) is a database of people who may wish to help public health personnel respond to an act of terrorism or other public health emergency. It is coordinated with Georgia's public health and Medical Reserve Corps (MRC) volunteer programs. Filling out this form will help connect you with your local MRC unit. The Central Georgia Medical Reserve Corps serves Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Peach, Putnam, Monroe, Twiggs, Washington and Wilkinson counties. There are other MRC units serving other parts of Georgia.

If you can, please sign up at the <http://www.servga.gov> web site. When filling out the application, be sure to designate "Central Georgia Medical Reserve Corps" as the unit you are joining. If you are unable to sign up online or prefer to register using this paper application, we will be happy to assist you. If you sign up online you will not need to complete the paper application.

If you are already registered with SERVGA, please add "Central Georgia Medical Reserve Corps" as one of your unit affiliations (in your SERVGA profile).

Registering places you under no legal obligation to volunteer. For further questions or information about our MRC unit, please visit our web site at www.northcentralhealthdistrict.org/mrc or contact us at the address or phone number listed above. For more information about the national MRC program, go to <http://www.mrc.hhs.gov>. For more information about the online volunteer registry, go to <https://www.servga.gov>

Data privacy

Information collected through the registry will be kept private or non-public, except where required by law. Only DHR and its federal, regional, and local partners involved in planning, investigating, or controlling a public health emergency will have access to this information. These partners could include both public health and law enforcement as well as MRC units with whom you affiliate. Providing information to this registry is voluntary. If you decide not to provide this information, however, we may not be able to contact you for emergency volunteer work.

Please return completed applications to:

**Central Georgia Medical Reserve Corps
c/o Office of Emergency Preparedness
201 Second Street, Suite 1100
Macon, GA 31201
Or fax to: (478) 751-4575**

Membership Application for entry in SERVGA

*** THIS SYMBOL INDICATES THAT THE INFORMATION IS REQUIRED.**

Section 1: First tell us some information about yourself....		
1. Personal information:		
*First name:	Middle name:	*Last name:
*Gender: <input type="checkbox"/> M <input type="checkbox"/> F	*Date of birth (mm/dd/yyyy):	*Georgia county you live in:
*Home address:	*City:	*Zip Code:
* Drivers License/State ID# :	*License State:	Exp. Date:
Primary email address:	Alternate email address:	Social Security #:
2. What is the best way to contact you in the event of an emergency?		
* 2a. Primary contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager	*Number:
2b. Secondary contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager	*Number:
2c. Emergency Contact Information:		
Name:	Relationship:	
Primary Contact #:	Secondary Contact #:	
*3. Do you have any military service obligations in the event of an emergency?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain what they are:		
*4. Do you have any other commitments that might pose a conflict in the event of an emergency? If yes, please identify them below:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> American Red Cross	<input type="checkbox"/> Hospital/clinic (name) :	<input type="checkbox"/> First Responder
<input type="checkbox"/> Other:		
Section 2: Tell us about your work....		
5. What is your employment status?		
<input type="checkbox"/> full time	<input type="checkbox"/> part time	<input type="checkbox"/> on call <input type="checkbox"/> not employed <input type="checkbox"/> retired <input type="checkbox"/> student
6. Do you work at more than one location?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6a. If yes, at how many locations do you work?
7. In which county or counties do you work?		
Please list the counties:	County in state bordering Georgia:	
8. In what type of setting do you work? (check all that apply)		
Health care settings:		Other health-related settings:
<input type="checkbox"/> Clinic <input type="checkbox"/> Emergency room <input type="checkbox"/> Home care/hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Intensive care <input type="checkbox"/> Laboratory/X-ray/other diagnostic procedures <input type="checkbox"/> Medical/surgical <input type="checkbox"/> Nursing home	<input type="checkbox"/> OB/GYN <input type="checkbox"/> Operating room/recovery room <input type="checkbox"/> Pediatrics <input type="checkbox"/> Pharmacy <input type="checkbox"/> Psychiatric/behavioral care/mental health <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Assisted living <input type="checkbox"/> Correctional facility <input type="checkbox"/> Emergency communications center <input type="checkbox"/> EMS provider <input type="checkbox"/> Group home <input type="checkbox"/> Public health department <input type="checkbox"/> Public safety/police department <input type="checkbox"/> School <input type="checkbox"/> Other : _____
8a. In what types of activities are you involved on your job? [check all that apply]		
<input type="checkbox"/> Administration <input type="checkbox"/> Case management <input type="checkbox"/> Clerical <input type="checkbox"/> Clinical services <input type="checkbox"/> Disease investigation and control <input type="checkbox"/> EMS education <input type="checkbox"/> EMS medical direction/coordination <input type="checkbox"/> Environmental health	<input type="checkbox"/> Epidemiology <input type="checkbox"/> First responder <input type="checkbox"/> Health counseling <input type="checkbox"/> Health education or promotion <input type="checkbox"/> Immunizations <input type="checkbox"/> Insurance/utilization review <input type="checkbox"/> Medical priority dispatching <input type="checkbox"/> Patient care	<input type="checkbox"/> Program planning <input type="checkbox"/> Quality improvement/assurance <input type="checkbox"/> Research <input type="checkbox"/> Supervision <input type="checkbox"/> Teaching <input type="checkbox"/> Telephone triage <input type="checkbox"/> Other: _____

*This information is required.

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22. If yes, please check your primary occupation from the list below, or choose the one that most closely matches your experience (if more than one occupation, please list in question #23):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Advanced Practical Nurse | <input type="checkbox"/> Health Educator | <input type="checkbox"/> Occupational Health Technician | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Public Health Administration |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Human Services Technician | <input type="checkbox"/> Occupational Therapist Aide | <input type="checkbox"/> Public Health Case Manager |
| <input type="checkbox"/> Behavioral Health Professional | <input type="checkbox"/> Immunization Services Worker | <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> Public Health Nurse |
| <input type="checkbox"/> Cardiovascular Tech | <input type="checkbox"/> Laboratorian | <input type="checkbox"/> Optician | <input type="checkbox"/> Radiation Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Radiologic Technician / Technologist |
| <input type="checkbox"/> Clinical Social Worker | <input type="checkbox"/> Marriage & Family Therapist | <input type="checkbox"/> Orthotist or Prosthetist | <input type="checkbox"/> Recreational Therapist |
| <input type="checkbox"/> Counselor/Mental Health | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Personal and Home Care Aide | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Counselor/Rehabilitation | <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Counselor/School | <input type="checkbox"/> Medical Equipment Preparer | <input type="checkbox"/> Pharmacy Aide | <input type="checkbox"/> Respiratory Therapy Technician |
| <input type="checkbox"/> Counselor/Substance Abuse | <input type="checkbox"/> Medical Records Technologist | <input type="checkbox"/> Pharmacy Technician | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Medical Transcriptionist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Diagnostic Sonographer |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Medical /Clinical Lab Technician | <input type="checkbox"/> Physical Therapist Aide | <input type="checkbox"/> Special Needs Care Provider |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Medical/Clinical Lab Technologist | <input type="checkbox"/> Physical Therapist Assistant | <input type="checkbox"/> Speech Language Technologist |
| <input type="checkbox"/> Dietetic Technician | <input type="checkbox"/> Medical/Health Service Manager | <input type="checkbox"/> Physician | <input type="checkbox"/> Surgical Technologist |
| <input type="checkbox"/> Dietician | <input type="checkbox"/> Nuclear Medicine Technologist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Toxicologist |
| <input type="checkbox"/> EMT-Basic | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> EMT-Paramedic | <input type="checkbox"/> Aide, Orderly or Attendant | <input type="checkbox"/> Psychiatric Aide | <input type="checkbox"/> Veterinary Assistant |
| <input type="checkbox"/> Environmental Health Inspector | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Psychiatric Rehabilitation Worker | <input type="checkbox"/> Veterinary Technician / Technologist |
| <input type="checkbox"/> Epidemiologist | <input type="checkbox"/> Occupational Health Specialist | <input type="checkbox"/> Psychiatric Technician | |
| <input type="checkbox"/> Other: | | | |

23. Please briefly describe the educational and/or work background you have that is relevant to volunteering in the event of a public health emergency (for example, "I graduated with an associate degree in medical technology in 1988 from the Columbus Technical College. Since graduating, I have worked full-time as a clinical laboratory technician for Emory University Hospital's central lab. I recently began taking classes on a part-time basis to complete a bachelor's degree in medical technology at Emory University.")

ADDITIONAL INFORMATION FOR NURSES, DOCTORS, PHARMACISTS, and DENTISTS:

- If you are a **NURSE**, please continue with **Section 5**.
- If you are a **DOCTOR**, please continue with **Section 6**.
- If you are a **PHARMACIST**, please continue with **Section 7**.
- If you are a **DENTIST**, please continue with **Section 8**.

IF YOU ARE NOT A NURSE, DOCTOR, PHARMACIST OR DENTIST, PLEASE CONTINUE WITH SECTION 9.

Section 5: Nurses ONLY

*24. Are you an advanced-practice registered nurse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is your classification?		If yes, what is your specialty?
*25. Do you have a specialty certification?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate below (check all that apply.)
<input type="checkbox"/> Direct patient care	<input type="checkbox"/> Mass immunization	<input type="checkbox"/> Phlebotomy
<input type="checkbox"/> Disease investigation	<input type="checkbox"/> Mental health	<input type="checkbox"/> Public health nursing
<input type="checkbox"/> ER	<input type="checkbox"/> Military medic	<input type="checkbox"/> School nursing
<input type="checkbox"/> Home health care	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Trauma
<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Patient education	<input type="checkbox"/> Triage
<input type="checkbox"/> Mass care	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Other:

PLEASE CONTINUE WITH SECTION 9.

Section 6: Doctors ONLY

24. Are you an EMS medical director or have other emergency medicine experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Have you provided care in an atypical setting as part of your current or prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. What percentage of your practice is ongoing care/scheduled appointments that could be re-scheduled in case of a large-scale emergency?	
<input type="checkbox"/> 0-10%	<input type="checkbox"/> 11-24%
<input type="checkbox"/> 25-49%	<input type="checkbox"/> 50-74%
<input type="checkbox"/> 75-100%	

*This information is required.

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***27. What would you consider yourself capable of and agreeable to perform if needed [check all that apply]:**

- | | | |
|--|--|---|
| <input type="checkbox"/> providing acute patient screening | <input type="checkbox"/> providing hospice care | <input type="checkbox"/> performing vaccinations |
| <input type="checkbox"/> providing ambulatory care | <input type="checkbox"/> providing nursing home care | <input type="checkbox"/> screening vaccination candidates |
| <input type="checkbox"/> providing hospital/ field hospital care | <input type="checkbox"/> providing telephone information | <input type="checkbox"/> providing non-medical assistance |

***28. What is your primary specialty?**

- | | | |
|--|--|---|
| <input type="checkbox"/> allergy, asthma, immunology | <input type="checkbox"/> gastroenterology | <input type="checkbox"/> pediatrics |
| <input type="checkbox"/> anesthesiology | <input type="checkbox"/> gerontology | <input type="checkbox"/> physical medicine and rehabilitation |
| <input type="checkbox"/> behavioral medicine | <input type="checkbox"/> internal medicine | <input type="checkbox"/> plastic and reconstructive surgery |
| <input type="checkbox"/> cardiology | <input type="checkbox"/> infectious disease medicine | <input type="checkbox"/> psychiatry / child psychiatry |
| <input type="checkbox"/> clinical oncology | <input type="checkbox"/> neurological surgery | <input type="checkbox"/> public health medicine |
| <input type="checkbox"/> clinical endocrinology | <input type="checkbox"/> neurology | <input type="checkbox"/> pulmonary medicine |
| <input type="checkbox"/> colon and rectal surgery | <input type="checkbox"/> obstetrics and gynecology | <input type="checkbox"/> radiology |
| <input type="checkbox"/> critical care medicine | <input type="checkbox"/> occupational/environmental medicine | <input type="checkbox"/> rheumatology |
| <input type="checkbox"/> dermatology | <input type="checkbox"/> oncology | <input type="checkbox"/> sleep medicine |
| <input type="checkbox"/> emergency medicine | <input type="checkbox"/> orthopedic surgery | <input type="checkbox"/> thoracic surgery |
| <input type="checkbox"/> ear, nose, and throat (ENT) | <input type="checkbox"/> ophthalmology | <input type="checkbox"/> vascular surgery |
| <input type="checkbox"/> family practice | <input type="checkbox"/> pathology | <input type="checkbox"/> other: |
| <input type="checkbox"/> forensic medicine | | |

28a. If you have a secondary specialty, please list:

29. Have you had experience in any of the following areas? [check all that apply]

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> administration | <input type="checkbox"/> hospice | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> research |
| <input type="checkbox"/> clinic | <input type="checkbox"/> intensive care | <input type="checkbox"/> other area related to emergency | <input type="checkbox"/> teaching |
| <input type="checkbox"/> counseling | <input type="checkbox"/> medical/surgical | <input type="checkbox"/> psychiatric/behavioral care | <input type="checkbox"/> utilization review |
| <input type="checkbox"/> ER | <input type="checkbox"/> operating room/recovery room | <input type="checkbox"/> pediatrics | <input type="checkbox"/> Other: |

***30. Do you have any special qualifications or interests we should be aware of?** Yes No

If yes, please list:

PLEASE CONTINUE WITH SECTION 9.

Section 7: Pharmacists ONLY

24. Have you provided care in an atypical setting as part of your current or prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)? Yes No

If yes, please describe:

***25. What setting do you currently work in? [mark all that apply]**

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrative office | <input type="checkbox"/> Hospital pharmacy | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Clinic pharmacy | <input type="checkbox"/> Home I.V. therapy | <input type="checkbox"/> Nuclear pharmacy |
| <input type="checkbox"/> Clinical pharmacy | <input type="checkbox"/> HMO clinic pharmacy | <input type="checkbox"/> Nursing home pharmacy |
| <input type="checkbox"/> Community / Retail | <input type="checkbox"/> Industry | <input type="checkbox"/> Pharmacy school/medical school / teaching hospital |
| <input type="checkbox"/> Other | | |

***26. Which activities do you participate in? [mark all that apply to your professional activity]**

- | | | |
|---|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Disease state management | <input type="checkbox"/> Pharmacy benefits management |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Research | <input type="checkbox"/> Teaching |
| <input type="checkbox"/> Dispensing prescriptions | <input type="checkbox"/> Sales | <input type="checkbox"/> Other (specify) |

***27. What would you consider yourself capable of and agreeable to perform if needed? [check all that apply]:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Administering medication | <input type="checkbox"/> Interpreting medication orders | <input type="checkbox"/> Providing telephone information |
| <input type="checkbox"/> Assuring appropriate drug/dose | <input type="checkbox"/> Providing education on treatments | <input type="checkbox"/> Screening vaccination candidates |
| <input type="checkbox"/> Dispensing medication | <input type="checkbox"/> Providing non-medical assistance | <input type="checkbox"/> Vaccinations |

***28. In which specialty area(s), if any, are you certified:**

- Nutrition support Nuclear pharmacy None Psychiatric Pharmacotherapy Other:

***29. Do you have a subspecialty?** Yes No If yes, name of subspecialty:

30. Please indicate whether you are certified and/or trained in providing influenza and pneumococcal immunizations. Yes No

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31. Do you have experience in conducting comprehensive patient assessments and in interpreting and adjusting drug therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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32. Do you have experience in any of the following areas? [check all that apply]
<input type="checkbox"/> Emergency room <input type="checkbox"/> Intensive care <input type="checkbox"/> Pediatrics <input type="checkbox"/> Primary care medicine <input type="checkbox"/> Psychiatry

PLEASE CONTINUE WITH SECTION 9.

Section 8: Dentists ONLY

*24. Do you have any specialized training or board certification in the dental field?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If "yes", indicate the specialized training or board certification you received. [Fill in all that apply]

<input type="checkbox"/> Endodontics	<input type="checkbox"/> Oral surgery	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Periodontics	<input type="checkbox"/> Public health
<input type="checkbox"/> Forensic odontology	<input type="checkbox"/> Oral pathology	<input type="checkbox"/> Pediatric dentistry	<input type="checkbox"/> Prosthodontics	<input type="checkbox"/> Other:

*25. What is your primary professional activity? [Fill in only one]
--

<input type="checkbox"/> Administration	<input type="checkbox"/> Consulting	<input type="checkbox"/> Research	<input type="checkbox"/> Teaching
<input type="checkbox"/> Advanced dental study	<input type="checkbox"/> Patient care	<input type="checkbox"/> Sales	<input type="checkbox"/> Other (specify):

26. Have you provided care in an atypical setting as part of prior employment (e.g., field military, wilderness medicine, Third World settings, or similar)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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*27. Are you on staff at a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:
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28. What percentage of your practice is ongoing care/scheduled appointments that could be re-scheduled in case of a large-scale emergency?

0-10% 11-24% 25-49% 50-74% 75-100%

*29. Which activities would you consider yourself capable of and agreeable to perform if needed and training were provided? [check all that apply]

<input type="checkbox"/> providing acute patient screening and care (clinic setting)	<input type="checkbox"/> providing non-medical assistance
<input type="checkbox"/> providing hospital care (or care in field hospital)	<input type="checkbox"/> screening vaccination candidates
<input type="checkbox"/> providing telephone information	<input type="checkbox"/> vaccinations

30. Have you had recent experience in any of the following areas? [check all that apply]

<input type="checkbox"/> administration	<input type="checkbox"/> ER	<input type="checkbox"/> medical/surgical	<input type="checkbox"/> research
<input type="checkbox"/> clinic	<input type="checkbox"/> hospice	<input type="checkbox"/> operating room/recovery room	<input type="checkbox"/> teaching
<input type="checkbox"/> counseling	<input type="checkbox"/> intensive care	<input type="checkbox"/> pediatrics	<input type="checkbox"/> utilization review
<input type="checkbox"/> Other area related to emergency care:			

Section 9: (ALL applicants complete)

How did you hear about the opportunity to volunteer in a health emergency?

<input type="checkbox"/> brochure/flyer	<input type="checkbox"/> mailing	<input type="checkbox"/> TV/radio	<input type="checkbox"/> professional organization	<input type="checkbox"/> article/publication
<input type="checkbox"/> internet	<input type="checkbox"/> presentation	<input type="checkbox"/> friend/acquaintance	<input type="checkbox"/> other: _____	

Do you want your account to be:

Active: Your account information will be available to authorized system administrators. You will be eligible to be contacted for emergency deployments and receive notifications related to potential emergency activations and deployments.

Inactive: Your account information will be available to authorized system administrators, however, you will NOT be considered for or contacted about potential emergency activations and deployments. You may receive non-emergency notifications related to the status of your account

Acknowledgment

I hereby certify that all statements made in this application are true and I agree and understand that any misstatement of material facts may cause forfeiture of my eligibility for enrollment as a Medical Reserve Corps volunteer. I also understand that falsification or omission of information may result in my removal from eligibility as a volunteer. I understand that submitting this application does not guarantee selection for placement. I understand that the information from this application will be entered into the ServGA website and may be shared with federal, state, regional or local partners in planning for emergency preparedness and with those agencies where I will be placed as a volunteer. I authorize my Medical Reserve Corps officials to check any information regarding my application and information about criminal background and will agree to submit a separate form indicating authorization to release this information. I understand that I have the right to withdraw my application or discontinue my enrollment as a volunteer at anytime with written notification to my MRC office.

*Signature	*Date
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*This information is required.



CENTRAL GEORGIA MEDICAL RESERVE CORPS

CERTIFICATION

I (Name, please print) _____ certify that:

a. I am in adequate physical condition to perform my duties as a volunteer of the Central Georgia Medical Reserve Corps.

b. I have/have not been a member of a Medical Reserve Corps in the past. If you have, which one? _____

May we contact them? Yes/No

c. I have/have not been arrested and or convicted of any crime. (Circle one; if yes, please briefly explain.)

d. I hereby give permission to the Central Georgia Medical Reserve Corps to conduct a criminal background check and social security number verification.

Signature

Date