



VOLUNTEER APPLICATION

Please print or type

Name		Age:	Eye Color:
Street Address (Mailing)		Height:	Weight:
City	State	Zip	
Home Phone	Work Phone	Cell Phone	
Email		Cell Phone Carrier	
Type: Medical Professional: <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Dentist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Veterinarian		Emergency contact information: Name: Address: Home #: Cell #:	
<input type="checkbox"/> Mental Health <input type="checkbox"/> Social Worker <input type="checkbox"/> EMT <input type="checkbox"/> Non Medical <input type="checkbox"/> Other _____			
License or Certificate/Registration Number:		Languages:	Drivers License #:
I have read of the conflict of interest law *Pages: 2,3 and 4 of this document		State License Held:	Expiration Date:
Level of Participation Desired: I prefer to be: <input type="checkbox"/> ACTIVE Receive notifications of ALL training opportunities, training drills & exercises, Emergency events, as well as non-emergency volunteer opportunities <input type="checkbox"/> LIMITED Receive only notification of training drills & exercises and all emergency events			
Volunteer Interests: Check all that apply: Administration___ Public Safety___ Phone Bank___ Steering Committee___ Clinical___ Fundraising___ Database___ Newsletter Production___ Volunteer Coordination___ Behavioral Health___ Deliveries___ Clerical Help___			
Mass Dept. of Public Health-MA Responds or Region 4A MRC has been certified by the Department of Criminal Justice Information Services (formerly the Criminal History Systems Board) for access to conviction and pending criminal case data. As an applicant for the Medical Reserve Corps, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information contained herein is correct to the best of my knowledge.			
Date of Birth ___/___/___ Social Security (last six digits) #___-___			
Signature _____ Date ___/___/___			
http://www.mass.gov/eopss/docs/chsb/803-cmr-2-00-criminal-offender-record-information-cori.pdf			
Location Preference for Responding: Check all that apply			
Your town only <input type="checkbox"/>	Region 4a <input type="checkbox"/>	New England <input type="checkbox"/>	Anywhere in the US <input type="checkbox"/>
Surrounding Towns <input type="checkbox"/>	State <input type="checkbox"/>	East Coast <input type="checkbox"/>	Anywhere in the world <input type="checkbox"/>
Signature			Date

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 and all information will be kept in a secure manner.

Board of Health

William Morris, Chairman
Mary Dolan Ciapciak, Clerk
Richard Bringham, MD
Claire Wolfram
Carol Johnson



Town Hall
135 School Street
Walpole, Massachusetts 02081
Phone (508) 660-7321
Fax (508) 660-6345

Town of Walpole
Commonwealth of Massachusetts

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CORI REQUEST FORM

The Walpole Board of Health has been certified by the Criminal History Systems Board for access to all criminal case data including conviction, non-conviction and pending. As an applicant/ employee for the position of **Medical Reserve Corp (MRC) volunteer**, I understand that a criminal record check will be conducted for conviction, non-conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

APPLICANT/EMPLOYEE SIGNATURE

APPLICANT/EMPLOYEE/INFORMATION (PLEASE PRINT)

LAST NAME

FIRST NAME

MIDDLE NAME

MAIDEN NAME OR ALIAS (IF APPLICABLE)

PLACE OF BIRTH

DATE OF BIRTH

SOCIAL SECURITY NUMBER
(Requested but not required)

ID Theft Index PIN
(if applicable)

MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

SEX: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ EYE COLOR: _____

STATE DRIVER'S LICENSE NUMBER: _____

***THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF
GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

REQUESTED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

*The CHSB Identity Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614