



CROSS COUNTY MEDICAL RESERVE CORPS VOLUNTEER APPLICATION

COLLIN COUNTY MEDICAL RESERVE CORPS, 4300 COMMUNITY AVE., MCKINNEY, TX 75071

WWW.METROPLEXVOLUNTEERS.COM



PERSONAL INFORMATION

Last Name		First Name		Middle Initial	Date of Birth
Street Address		City	County	State	Zip Code
Cellular Number	Work Number	Home Number		Fax Number	
Drivers License Number		State	Social Security Number - -		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Email			Secondary Email		
Amateur Radio Operator:	Call Sign	License Class	Languages Spoken Fluently		

PROFESSIONAL INFORMATION

Employer Name		Profession		Employer Contact Number	
Street Address		City	County	State	Zip Code
Licensed and Clinical Providers:					
Physicians/Surgeons: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Retired				Specialty:	
Allied Health: <input type="checkbox"/> OD <input type="checkbox"/> DC <input type="checkbox"/> DPM <input type="checkbox"/> DVM <input type="checkbox"/> Retired				Specialty:	
Mid-Level Providers: <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> CNS <input type="checkbox"/> CNM <input type="checkbox"/> CRNA <input type="checkbox"/> Retired				Specialty:	
Dentistry: <input type="checkbox"/> DDS <input type="checkbox"/> RDH <input type="checkbox"/> RDA <input type="checkbox"/> Retired					
Nursing: <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> Retired				Specialty:	
Pharmacy: <input type="checkbox"/> DrPh <input type="checkbox"/> RPh <input type="checkbox"/> RPT <input type="checkbox"/> Retired					
Mental Health: <input type="checkbox"/> PsycD <input type="checkbox"/> PhD <input type="checkbox"/> LSW <input type="checkbox"/> CSW <input type="checkbox"/> LPC <input type="checkbox"/> CISM <input type="checkbox"/> Other: _____ <input type="checkbox"/> Retired					
First Responders: <input type="checkbox"/> EMT <input type="checkbox"/> EMT-P <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other: _____ <input type="checkbox"/> Retired					

EMERGENCY CONTACT INFORMATION

Last Name	First Name	Phone Number
Street Address	City	Email

Collin County completes a criminal background check on all Medical Reserve Corps volunteers. Your signature acknowledges that you have been advised on this policy and give permission for the county to complete this investigation.

Signature of Applicant

Date

For Official Use Only

Date Application Received: _____
Date Application Approved: _____

Date Background Check Performed: _____
Date Professional License Reviewed: _____