

Boxford
Middleton
Topsfield



Public Health

H1N1 VOLUNTEER APPLICATION

Name		DOB		Age	
Street Address					
City/Town			State		Zip
Home Phone		Work Phone		Cell Phone	
Email Addresses 1. 2.			Employer Name and Address		
Occupation <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Dentist <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Firefighter <input type="checkbox"/> Policeman		<input type="checkbox"/> Paramedic <input type="checkbox"/> EMT <input type="checkbox"/> Veterinarian <input type="checkbox"/> Medical Assistant <input type="checkbox"/> Nursing Assistant <input type="checkbox"/> Other/Retired Please describe: _____ _____		Volunteer Emergency Contact Information Name _____ Relationship to Volunteer _____ Address _____ Home# _____ Work # _____ Cell # _____	
Professional License or Certificate _____ Registration Number _____ State License Held _____ Expiration Date _____			Driver's License #: State License Held: _____ Expiration Date: _____		
Trainings/Certifications Held <input type="checkbox"/> First Aid <input type="checkbox"/> CPR <input type="checkbox"/> ALS <input type="checkbox"/> PALS <input type="checkbox"/> ICS <input type="checkbox"/> NIMS <input type="checkbox"/> Other _____ Are you trained to vaccinate? Y N					
Volunteer Interests: Please Check All That Apply (training will occur on-site, as needed) <input type="checkbox"/> Traffic Safety <input type="checkbox"/> Pedestrian Safety <input type="checkbox"/> Security <input type="checkbox"/> Greeter <input type="checkbox"/> Initial Screener <input type="checkbox"/> Waiting Room <input type="checkbox"/> Patient Refreshment <input type="checkbox"/> Clerical <input type="checkbox"/> Runner <input type="checkbox"/> Registration <input type="checkbox"/> Volunteer Orientation(once trained) <input type="checkbox"/> Wherever needed <input type="checkbox"/> Staff Refreshment/Break Room <input type="checkbox"/> Licensed Vaccinator <input type="checkbox"/> Vaccine Manager <input type="checkbox"/> Vaccinator Assistant <input type="checkbox"/> Emergency Medical Treatment					
Please provide us with your anticipated availability: I have availability on <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends <input type="checkbox"/> 4 hour shift <input type="checkbox"/> 8 hour shift <input type="checkbox"/> Days <input type="checkbox"/> Evenings Languages Spoken (other than English):					
NOTE: All volunteers will automatically undergo a Criminal Offender Reporting Index (CORI) at no cost.					
Signature				Date	

Privacy Act Statement

This information is requested by the Tri-Town H1N1 Clinic planners for the purpose of organizing volunteers and staff. 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 location. **NOTE: H1N1 Clinic Volunteer names will be kept by the Topsfield Regional MRC as well as the Health Department of the community in which the volunteer lives.**

Mail Application To: **Topsfield Board of Health**
TRMRC Consultants
Topsfield Town Hall
8 W. Common Street
Topsfield, MA 01983