

STARK COUNTY HEALTH DEPARTMENT VOLUNTEER INFORMATION SHEET

Send completed form to 3951 Convenience Circle NW Canton, Ohio 44718
or fax to 330-493-9920 Attn: Dianne Myers

Personal Contact Information

Dr. Mrs. Mr. Ms. (Circle one)

Last Name _____ First Name _____ MI _____

Maiden Name/Other Names Used: _____ OH Driver's License # _____

Home Address: Street _____ Apt. # _____

County _____ City _____ State _____ Zip Code _____

Home Phone # () _____ Cell Phone # () _____ Home Fax # _____

E-mail Address _____ Personal Pager # () _____

Amateur Radio Callsign _____ License Class _____

Have you ever been convicted of a felony? Y N A misdemeanor?(other than traffic violations) Y N
If yes please explain:

In case an emergency happens *to me* please contact:

Name _____ Relationship _____

Daytime phone number _____ Evening phone number _____

Volunteer Interest Area

Do you have any personal health issues that would impact your ability to volunteer? Yes No
(For example, allergies, medication issues, disabilities, special needs, or being treated for a medical condition.) If yes, please explain or list here:

Work Contact Information

Occupation _____ (check) Full Time Part Time Retired Student

Employer _____ Address _____

General Phone Number () _____ Your extension _____ Fax # _____

May we contact you at work in the event of an emergency? Yes No

In the event volunteers are called to respond to an emergency: Please list additional person(s) who may be used to contact you if we are unable to reach you using the information provided above.

Contact _____ Phone Number () _____ Relationship _____

Continued on reverse side

Education (check highest level)

High School College Graduate School Other

School Name _____ Location _____

Type of Degree _____ Major/Specialization _____ Year Graduated _____

License (Professionals with a current license or certification in any health or mental health field)

Circle all applicable: State Issued Expiration Date

- 1. M.D./D.O. _____
- 2. D.D.S./D.M.D. _____
- 3. D.C. _____
- 4. R.N. _____
- 5. L.P.N. _____
- 6. EMT/Paramedic _____
- 7. P.A./N.P. _____
- 8. Other health related degrees or licenses _____

In the event you are called upon to volunteer, you will be expected to provide verification of your licensure as well as a current photo ID.

Certifications & Training (check all that apply)

Certifications	Most Recent Date	Certifying Agency
<input type="checkbox"/> CPR	_____	_____
<input type="checkbox"/> First Aid	_____	_____
<input type="checkbox"/> Disaster Training	_____	_____
<input type="checkbox"/> CERT	_____	_____
<input type="checkbox"/> Bloodborne Pathogens & Standard Precautions	_____	_____
<input type="checkbox"/> Other certifications	_____	_____

Are you part of an emergency/disaster plan with any other organization? (Such as the American Red Cross, a local hospital, etc.)

If yes, please list below. Yes No

I hereby certify that all of the information submitted on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered my application may be rejected.

Signature of volunteer

Date