



KENDALL COUNTY HEALTH DEPARTMENT
811 John Street, Yorkville, IL 60560 (630) 553-9100 FAX (630) 553-9604

Kendall County Health Department Volunteer Responders Volunteer Application and Contact/Information Sheet

Date: _____

Name		
Last: _____	First: _____	MI: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen: <input type="checkbox"/> No <input type="checkbox"/> Yes	

Home Address and Contact Information

Street: _____		
City: _____	State: _____	Zip Code: _____
Home Phone #: _____	E-mail Address: _____	
Cell Phone #: _____	Work Phone #: _____	
Other (specify): _____	Preferred method of contact: _____	

Emergency Information

Emergency Contact: _____	Relationship _____	
Home Phone #: _____	Work Phone #: _____	Cell Phone #: _____

Work Information

Occupation: _____	Check One: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Student
Job Position: _____	Employer: _____
Obligated to another emergency/disaster response team (hospital, Red Cross, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, identify obligation: _____	

Education

Dates	Institution	Major	Degree

Military Experience

Have You Ever Served in the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch _____	
Active Duty Period _____	Discharge Date ____/____/____	Discharge Type _____
Are You Presently a Member of a Reserve or National Guard Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever been convicted of a felony or a misdemeanor (other than a traffic violation)? Yes No

Additional Pertinent Information

Include allergies, special considerations, limitations, etc.



Licenses/Certifications/Skills (Please attach copies of credentials, licenses, registrations, training):		
<input type="checkbox"/> Doctor <input type="checkbox"/> Nurse/LPN/CNA <input type="checkbox"/> Nurse Practitioner/Physician Asst. <input type="checkbox"/> Dentist <input type="checkbox"/> Pharmacist/Pharmacy Tech. <input type="checkbox"/> Psychiatrist/Psychologist <input type="checkbox"/> Veterinarian <input type="checkbox"/> Mental Health <input type="checkbox"/> Social Worker	<input type="checkbox"/> Paramedic/EMT <input type="checkbox"/> Non-Medical <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Fire Fighter <input type="checkbox"/> Educator <input type="checkbox"/> Environmental Engineer <input type="checkbox"/> Environmental Health Practitioner	<input type="checkbox"/> Other (Describe): Languages Spoken (Identify):
License or Certificate/Registration No.:	Expiration:	Drivers License No.:
Are you licensed to dispense prescription medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you licensed to administer vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List any Incident Command System (ICS) or National Incident Management System (NIMS) training you have completed (Please attach Certificates of Completion):		

I attest that I am at least 18 years of age and do not require parental or guardian authorization to enter into this agreement. All of the information that I have supplied is correct to the best of my knowledge. If information given in this application is incomplete or untrue, I understand my assignment may be terminated. I do hereby give the Kendall County Health Department (KCHD) permission to inquire into my educational background, driving record, present employment, licenses, certifications, and police record. I further give permission to the holder of any such records to release the same to the KCHD. I hold the KCHD harmless of any liability, whether civil or criminal, which may arise as a result of the release of information about me. I also hold harmless any individual agency, business, or corporation that provides information to the KCHD.

I understand that I am a volunteer participating at my own risk and will not be paid for any of my services. I also understand that my own insurance will be used as primary coverage for illnesses and injuries and that I am ultimately responsible while serving as a volunteer. I state that I have no health or physical problems that will interfere with my health or my performance as a volunteer.

I give permission for the KCHD to release personal information to local, state, and Federal emergency management agencies and other Health and Human Service agencies as needed.

BY SIGNING THIS VOLUNTEER AGREEMENT AND RELEASE, I ACKNOWLEDGE THAT I HAVE READ ITS CONTENTS, THAT I UNDERSTAND ITS CONTENTS, AND THAT I AGREE TO ITS TERMS.

Signature: _____ Printed Name _____

Date ____ / ____ / ____

Please Return Completed Application to: Emergency Response Coordinator
FAX: (630) 553-9604 or **Mail:** Kendall County Health Department
811 West John Street, Yorkville, IL. 60560