CR-MRC

Capitol Region Medical Reserve Corps
Membership Application

Capitol Region Medical Reserve Corps
c/o Capital Region Council of Governments
241 Main Street
Hartford, CT 06106-5310
capitolregionmrc@gmail.com

Important information- read carefully
Please type or print legibly in black or blue ink
Items marked with an asterisk (*) must be completed
Print this form and Enter your information in each field.
Bring this form, including copies of your licenses/certifications, if applicable, to the next meeting.

Unit Names

Safety	Administration	Logistics	Physician
Pharmacist	RN	APRN	EMS
Behavioral Health	PA	Public health	Other Medical

*Last Name:	*First Name:	*Middle Initial	*Unit (Select one of the above)	
* Home mailing address	* City		* State	*Zip code
* Date of Birth	*Home Phone ( )	*Work phone ( )	*Cell phone ( )	
*Home email:	*Work email:			
*Name of Emergency contact	*Relationship	*Telephone ( )		

Providing this information is optional, but it may be valuable to CR-MRC in an emergency.		
Other language spoken or sign language-( )Fluent ( ) Well enough ( ) Slight		Would you be willing to be an interpreter in emergency? ( ) Yes ( ) No
Gender	Drug Allergies	Hospital preferred:

Do you have a current driver's license? Yes___ No___
Have you ever been convicted on a felony? Yes_____ No_____
Would you be willing to submit to a background check? Yes_____ No _____

I attest that the information provided in this application is correct and accurate to the best of my ability.

Print Name:_____

Signature_____Date:_____