Clinic Volunteer Registration Form

Please mail or fax your completed form to:

MDA #31
c/o Windsor Health Department
275 Broad Street
Windsor, CT 06095
Fax: 860.285.1864

DATE: _____

PLEASE PRINT CLEARLY – ALL FIELDS ARE REQUIRED

FIRST NAME: _____ **LAST NAME:** _____

Mailing Address: _____

Town: _____ **State:** _____ **Zip Code:** _____

Phone (Home): _____ **Phone (Work + ext)**_____

Cell Phone: _____**Fax:** _____

Home Email: _____

Work Email: _____

Gender: (circle) Male Female **Date of Birth:** _____

We will add your contact information to the Everbridge system for MDA 31 notification purposes. MDA 31 volunteers agree to participate in one annual drill to test our ability to reach you in an emergency.

Which is the FIRST way we should try to reach you in an emergency?

☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone** ☐ **Text Msg**

Do you have any experience or interests that would be useful in a clinic?

- ☐ **Customer Service**
- ☐ **Food Service**
- ☐ **Public Speaking/Media**
- ☐ **Secretarial**
- ☐ **Other** _____
- ☐ **Medical**
  Area:_____
- ☐ **Technology**
- ☐ **Translation**
  Language(s):_____

We will use this information for planning purposes only. You may change your mind at any time.

Please complete Background Inquiry Release and submit it with this form. For information, please call the Windsor Health Department at **860-285-1823.**

Version Date: 9/3/13

BACKGROUND INQUIRY RELEASE

I understand that an investigative inquiry is to be made of myself, including but not limited to, criminal history, driving history, work history, HHS/OIG/GSA (welfare fraud), and other reports. I hereby give my permission to Mass Dispensing Area (MDA) #31 and its partner agency, Windsor Independent Living Association (WILA), to request this information.

MDA 31 reserves the right to conduct a background inquiry upon receipt of a volunteer's initial application to join MDA 31 as well as periodically thereafter.

I hereby authorize, without reservation, any party or agency contacted to release full and complete information as may be requested by MDA 31 or WILA. I waive any right to view this information, and release MDA 31 and its partners from all liability for reporting any information provided below, as well as any other information that may be required at a later date.

Print Name: _____

Social Security Number: _____

Driver's License Number: _____

Medical License Number/State:_____

Medical License Number/State:_____

Current Address: _____

City / State / Zip: _____

Previous States Where You Have Lived in Past Two Years:

_____

Applicant's Signature: _____

Date: _____

This information will be shredded if you are not registered as an MDA 31 volunteer.