



Capital Medical Reserve Volunteer Registration Form



First Name	Last Name	Suffix	
Mailing Address			
City	State	Zip	County
Home Phone	Work Phone		Cell Phone
Email		Alternate Email	
Employer	Employer Address and Phone Number		

Please indicate your specialty area, check all that apply:

Category: Medical (MED)	Category: Non-Medical (NONMED)	Preferred contact method for information on training, drills, etc.
<input type="checkbox"/> CMA – Medical Assistant <input type="checkbox"/> DA – Dental Assistant <input type="checkbox"/> DDS – Dentist <input type="checkbox"/> DO – Doctor of Osteopathy <input type="checkbox"/> EMS – Paramedic <input type="checkbox"/> LPN – Licensed Practical Nurse <input type="checkbox"/> MD – Medical Doctor <input type="checkbox"/> MENTAL – Mental Health Professional <input type="checkbox"/> NP – Nurse Practitioner <input type="checkbox"/> PA – Physician Assistant <input type="checkbox"/> PH – Public Health <input type="checkbox"/> PHARM – Pharmacist <input type="checkbox"/> RN – Registered Nurse <input type="checkbox"/> RT – Respiratory Therapist <input type="checkbox"/> VET – Veterinarian <input type="checkbox"/> Other: _____	<input type="checkbox"/> CHILD – Childcare <input type="checkbox"/> CLER – Clerical <input type="checkbox"/> ENVIRO – Environmental Inspector <input type="checkbox"/> FAITH – Clergy Denomination: _____ <input type="checkbox"/> LEGAL – Legal Support <input type="checkbox"/> LOG – Logistic/Supply Specialist <input type="checkbox"/> PLAN – Planning <input type="checkbox"/> PI – Public Information Specialist <input type="checkbox"/> RADIO – HAM Radio Operator <input type="checkbox"/> SAFE – Law Enforcement/Safety <input type="checkbox"/> IT – Information Technology <input type="checkbox"/> TRANS – Translator/Interpreter Language(s): _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Mail to above address <input type="checkbox"/> Mail to: _____ _____ <input type="checkbox"/> Email <input type="checkbox"/> Alternate Email <input type="checkbox"/> Email to: _____ <input type="checkbox"/> Automated Phone Message <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Call: _____
License or Certificate/Registration Number:	License Type:	License Expiration Date:

Hospital or Medical Staff:

Would you be willing to verify your employment to increase your emergency credentialing level? Yes No
 If so, you must complete a verification form and submit it to KCHD on business letterhead, sample language provided. Contact Krista Farley for more information.

All Volunteers: Are you registered in wvredi.org? Yes No

PLEASE RETURN TO:

Krista Farley, Volunteer Coordinator
 Kanawha-Charleston Health Department
 108 Lee Street, E – Charleston, WV 25301

Phone: (304) 348-6493 Fax: (304) 348-6821 Email: Krista.N.Farley@wv.gov