



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	

<b>Home Address and Contact Information</b>		
Street: _____		
City: _____	State: _____	Zip Code: _____
Home Phone #: _____	E-mail Address: _____	
Cell Phone #: _____	Work Phone #: _____	
Other (specify): _____	Preferred method of contact: _____	

<b>Emergency Information</b>		
Emergency Contact: _____	Relationship: _____	
Home Phone #: _____	Work Phone #: _____	Cell Phone #: _____

<b>Work Information</b>		<i>Check One:</i>
Occupation: _____	<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: _____		

<b>Education</b>			
Dates	Institution	Major	Degree

<b>Military Experience</b>	
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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional Pertinent Information</b>
Include allergies, special considerations, limitations, etc.



<b>Licenses/Certifications/Skills</b> (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 <b>Incident Command System (ICS)</b> or <b>National Incident Management System (NIMS)</b> 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