



# STRATFORD-TRUMBULL-MONROE MEDICAL RESERVE CORPS VOLUNTEER APPLICATION

WHILE I UNDERSTAND THAT I MAY BE CALLED UPON TO SUPPORT ANY OF THESE COMMUNITIES, I WOULD PREFER TO VOLUNTEER FOR:	<input type="checkbox"/> STRATFORD HEALTH DEPARTMENT <input type="checkbox"/> TRUMBULL MONROE HEALTH DISTRICT <input type="checkbox"/> EITHER / BOTH EQUALLY
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**\* = REQUIRED FIELD**

TITLE ( <i>Mr, Mrs, Ms, etc.</i> )	* FIRST NAME	* LAST NAME	SUFFIX ( <i>Jr, Sr, etc.</i> )

OPTIONAL: <u>LAST 4 DIGITS ONLY</u> OF EITHER:	<input type="checkbox"/> SOCIAL SECURITY NUMBER	<input type="checkbox"/> DRIVER'S LICENSE NUMBER
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PAGER NUMBER	WORK PHONE	* HOME PHONE	CELL PHONE

WORK FAX NUMBER	HOME FAX NUMBER	WORK EMAIL	HOME EMAIL

HOME ADDRESS - LINE 1

HOME ADDRESS - LINE 2

HOME ADDRESS - CITY	HOME ADDRESS - STATE	HOME ADDRESS - ZIP

<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> HISPANIC / LATINO <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN	<input type="checkbox"/> ASIAN <input type="checkbox"/> HAWAIIAN <input type="checkbox"/> CAUCASIAN / WHITE
GENDER	*DATE OF BIRTH (mm/dd/yyyy)	OPTIONAL: ETHNICITY (Information requested by DPH)	

\* OCCUPATION

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold a current driver's license?	Do you have any physical limitations that would limit your ability to participate as a volunteer?

PRIMARY SPOKEN LANGUAGE	OTHER LANGUAGE(S) SPOKEN FLUENTLY (AND/OR FLUENCY IN SIGN LANGUAGE) <i>We are always looking for individuals who can provide translation services!!</i>

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