



Warren County Health Department
315 W. Washington Avenue, Washington New Jersey 07882
Phone: (908) 689-6693 Fax: (908) 689-3832
<http://www.co.warren.nj.us/healthdept/>

Health Care Professional Application

Personal Information- Please Print Clearly

Last Name	First Name	Middle Name	Nickname
Street Address	City	State	Zip
Mailing Address (If Different) Street	City	State	Zip
Home Phone Number		Home Fax Number	
Cell Phone Number		Pager number	
Home E-mail Address			
Date of Birth (Month/Day/Year)			
Driver's license Number	Expiration Date	Class	State

Emergency Contact-Will be notified if case of an emergency.

Last Name	First Name	Relationship	
Street Address	City	State	Zip Code
Home Phone Number		Work Phone Number	
Cell Phone Number		Pager Number	

Employment Information

Name of Employer			
Work Address	City	State	Zip
Work Phone Number		Work E-mail Address	



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Additional Information

Are you willing to travel and volunteer outside of your county? Yes ___ No ___
 Your Primary Language _____ Fluent ___ Speak ___ Read ___
 Other Language(s) _____ Fluent ___ Speak ___ Read ___
 Are you willing to provide translator service? Yes ___ No ___
 Do you have the ability to communicate using Sign Language? Yes ___ No ___
 Have you ever been vaccinated for smallpox? Yes ___ No ___
 If yes, what is the date of your most recent smallpox vaccination? _____
 Do you have any special needs or restrictions? If yes, explain.

Are you committed to any other organization or institution by virtue of employment or volunteerism in the event of an emergency? If yes, please explain.
 No ___ Yes ___ If yes, please explain.

Has your professional license or certification ever been suspended or revoked in New Jersey or any other state? No ___ Yes ___
 If yes, please explain.

Professional Licensure, Certification, Specialties, or Experience.

Name of License/s	Name of Certification/s
State License(s)/Certification Issued	Status (Active or Expired)
Specialty within the above professional licensure/certification that you possess:	
Subspecialty within the above professional licensure/certification process:	



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Professional Area and Skills of Expertise:

Please check the area of practice in which you are proficient for the skills of that profession.

Doctor of Medicine _____	Physician Assistant _____	First Responder _____
Doctor of Osteopathy _____	Nurse Practitioner _____	EMT/Paramedic _____
Doctor of Pharmacy _____	Registered Nurse _____	Occupational Therapist _____
Doctor of Dental Surgery _____	Dental Technician _____	Physical Therapist _____
Doctor of Medical Dentistry _____	Licensed Practical Nurse _____	Podiatrist _____
Psychologist _____	Licensed Practical Nurse _____	Nurse Midwife _____
Doctor of Public Health _____	Licensed Social Worker _____	Radiologist _____
Doctor of Theology _____	Licensed Clinical Social Worker _____	Research Scientist _____
Doctor of Nursing _____	Licensed Health Officer _____	Surgical Technician _____
Doctor of Ophthalmology _____	Ophthalmic Technician _____	Veterinarian _____
Registered Pharmacist _____	Certified Pharmacy Technician _____	Nursing Assistant _____
Epidemiologist _____	Laboratory Technician _____	Medical Assistant _____
Industrial Hygienist _____	Health Educator _____	Professional Student _____
Pastoral Care Professional _____	Linguists/Translator _____	Radiology Tech. _____
Licensed Funeral Director _____	Health Physicist _____	Surgical Tech. _____
Pharmacy Tech. _____	Nurse Anesthetist _____	Sociologist _____
Pharmacy Assist. _____	Microbiologist _____	Student _____
Public Information Officer _____	Infectious Disease Specialist _____	Other _____
Health Planner _____	Registered Environmental Health Specialist _____	

Training/Continuing Professional Education:

Have you ever participated in any training or continuing education programs in the following areas? If so, please check:

Advanced Cardiac Life Support _____	Hazardous Materials Training _____
Advanced Life Support _____	Hospital Preparedness _____
Basic Disaster Life Support _____	Incident Command (ICS) _____
Bloodborne Pathogens _____	Mental Health Training _____
CBRNE Training _____	Pediatric Life Support _____
OSHA Bloodborne Pathogens _____	Vaccination Administration _____
CERT Training _____	Triage _____
CPR/AED _____	Vaccination Administration _____
Exercise Design & Evaluation _____	Smallpox Vaccination _____
First Aid _____	Venipuncture _____
Fit Testing for Particulate Respirators _____	Weapons of Mass Destruction _____
Isolation & Quarantine _____	



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Expectations of Medical Reserve Corp Health Care Professional Volunteers:

As a volunteer with the New Jersey Medical Reserve Corps, I will be called upon to assist in the event of a public health emergency. I agree to attend an educational program to explain my role in disaster preparedness: I will be assigned duties based on my level of training and experience. I understand that submitting this application does not guarantee acceptance into the NJ Medical Reserve Corps. The information contained in this application is, to the best of my knowledge, truthful. I agree to serve my fellow citizens to the best of my ability.

Signature	Date
Print Name	Volunteer Position

I give my permission for my name and information to be entered into the New Jersey Medical Reserve Corps Data Base.

Signature	Date
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