

FARMINGTON VALLEY HEALTH DISTRICT  
CLINIC VOLUNTEER REGISTRATION FORM

MEDICAL

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you currently working in this area?     Yes                       No

Specialty: \_\_\_\_\_

License / Certification Information:    State: \_\_\_\_\_

License Type: \_\_\_\_\_ License # \_\_\_\_\_

Exp. Date: \_\_\_\_\_ Status:  Active     Inactive     Retired

In the event of an incident, will you need to respond to your place of  
employment or another agency?     Yes     No

If you are fluent in a language other than English, please list language(s) here:

\_\_\_\_\_

**Medical Volunteer Areas** (check all that apply)

- Physician Evaluator (MD, APRN, PA)
- Vaccinator (RN, *possibly dentists, veterinarians*)
- Medical Screening (RN)
- Triage
- Pharmacist
- EMT / Paramedic
- Mental Health Support
- Patient Education
- Exit Review

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Are you interested in being involved in Clinic Planning or in a Clinic

Manager position?     Yes             No             Maybe

Would you be interested in periodic training opportunities?

Yes             No             Maybe

Would you be willing to participate in drills and exercises?

Yes             No             Maybe

Any questions or comments: \_\_\_\_\_

\_\_\_\_\_  
FAX or MAIL completed form to:

Emergency Preparedness Coordinator  
Farmington Valley Health District  
95 River Road, Suite C  
Canton, CT 06019

Phone: (860) 352-2333  
Fax: (860) 352-2542

E mail: [info@fvhd.org](mailto:info@fvhd.org)  
Website: <http://www.fvhd.org>

**Thank You!**