

City of New Haven Volunteer Registration

TITLE FIRST NAME LAST NAME

GENDER REGISTRATION DATE:

STREET ADDRESS

CITY ZIP STATE

Please include area code below:

DAY PHONE EVENING PHONE CELL PHONE

PAGER E-MAIL FAX

BEST WAY TO CONTACT ME

BUSINESS ADDRESS

BUSINESS CITY BUSINESS STATE BUSINESS ZIP

OCCUPATION

EMPLOYER

DRIVER'S LICENSE # DRIVER'S LICENSE STATE

LICENSE EXPIRATION DATE

HAVE YOU EVER BEEN CONVICTED OF A: FELONY MISDEMEANOR

PLEASE CHECK OFF ANY SKILLS THAT YOU HAVE OR TASKS THAT YOU COULD PERFORM IN AN EMERGENCY

- | | | |
|---|--|---|
| <input type="checkbox"/> ASSIST WITH FORMS | <input type="checkbox"/> EVACUATION | <input type="checkbox"/> COMPUTER SUPPORT |
| <input type="checkbox"/> HAM RADIO OPERATOR | <input type="checkbox"/> EVIDENCE PRESERVATION | <input type="checkbox"/> INTERPRETER SERVICES |
| <input type="checkbox"/> TRAUMA | <input type="checkbox"/> ANIMAL CARE | <input type="checkbox"/> LABORATORY CAPACITY |
| <input type="checkbox"/> MENTAL HEALTH | <input type="checkbox"/> HEALTH SCREENINGS | <input type="checkbox"/> ASSIST WITH FLU CLINICS |
| <input type="checkbox"/> EDUCATION AND TRAINING | <input type="checkbox"/> GREETER | <input type="checkbox"/> TRIAGE |
| <input type="checkbox"/> SUPPLY/STOCK CONTROL | <input type="checkbox"/> SURVEILLANCE | <input type="checkbox"/> SECURITY/LAW ENFORCEMENT |

OTHER:

DO YOU SPEAK OR READ A LANGUAGE OTHER THAN ENGLISH (INCLUDING SIGN LANGUAGE)

LANGUAGE 1 **LANGUAGE 2**

ARE YOU CPR CERTIFIED? **ARE YOU PART OF ANY OTHER EMERGENCY/DISASTER ALERT SYSTEM. IF SO INDICATE WHICH**

PLEASE INDICATE WHEN YOU ARE AVAILABLE TO VOLUNTEER

SUNDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
MONDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
TUESDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
WEDNESDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
THURSDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
FRIDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>
SATURDAY	MORNING <input type="checkbox"/>	AFTERNOON <input type="checkbox"/>	EVENING <input type="checkbox"/>

EMERGENCY CONTACT NAME

EMERGENCY CONTACT ADDRESS

EMERGENCY CONTACT DAY PHONE **EMERGENCY CONTACT EVENING PHONE**

ARE YOU CURRENTLY LICENSED BY STATE OF CT TO ADMINISTER VACCINATIONS?

FOR MEDICAL PROFESSIONALS PLEASE COMPLETE THE FOLLOWING

PROFESSIONAL LICENSE # **PROFESSIONAL EXPIRATION DATE**

MEDICAL SPECIALTY

PHYSICIAN **PARAMEDIC** **PA** **NURSE ASSISTANT**
RN **PHARMACIST** **DENTIST** **HOME HEALTH AIDE** **EMT**
MENTAL HEALTH PRACTITIONER **VETERINARIAN** **NURSE PRACTITIONER**

Please Submit via Email Button or Print and Fax to: 203-946-7234