Public Health Emergency Volunteer Application

ST. CLAIR COUNTY HEALTH DEPARTMENT
Our Community. Our Environment.
www.scchealth.co | /scchdmi | @scchdmi

PERSONAL INFORMATION

Last Name / First / Middle	Date:
Street Address	Phone #:
City, State, Zip	Alternate contact #:
Have you ever been an employee of the health department? **Y** **N** If yes, Position: _____	Fax: Email:
Professionally Licensed, Registered or Certified: _____ State or Province of Issue: _____ Exp. Date:_____	Do you have a passport? **Y** **N** Do you have a valid driver's license or state ID? **Y** **N**
Do you have any special needs (Physical, mobility, diet, allergies, etc…)? **Y** **N** If yes, please explain:	Do you have your own transportation? **Y** **N**

EMPLOYMENT HISTORY

[ ] Currently Employed [ ] Retired [ ] Not Employed [ ] Current Student

Most Current or Recent Employer: _____ Position: _____Year(s): _____

Previous Employer: _____ Position: _____ Year(s): _____

Do you have a current employee photo identification badge? **Y** **N**

SPECIAL SKILLS, EXPERIENCES, OR TRAINING

☐ Computer/Data Entry ☐ Language Translation ☐ Trainer/Teacher ☐ Child Care ☐ Special Needs Care ☐ Animals/Pet Care	☐ Environmental ☐ Technician ☐ Security/Enforcement ☐ Sanitation ☐ Counseling/Mental Health ☐ Other _____	Please Describe :

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SPECIAL SKILLS, EXPERIENCES, OR TRAINING – CONTINUED

List any educational certificates, license, or degree you have:

Do you have any volunteer experience: **Y** **N** If yes, briefly describe:

REFERENCES

Non-Relative Reference	Name:	Address:	Phone:
Professional Reference	Name:	Address:	Phone:

STATEMENT

The information provided in the SCCHD Volunteer Application is true, correct and complete. If placed, any misstatement or omission of fact on this application may result in dismissal or denial. I understand that acceptance, as a volunteer does not create contractual obligation upon to the St. Clair County Health Department, or the County of St. Clair. If you decide to verify my personal or employment history, I authorize you to do so, and/or will provide copies of licensure, credentials, registrations and certifications upon request.

I understand I am obligated to adhere to governing laws and requirements as prescribed by the County of St. Clair, St. Clair County Health Department, and the State of Michigan as it may pertain to health, safety, and client confidentially.

Applicant Signature: _____ *Date:* _____

Submitting Application

1.) Please complete form and mail or fax to:
St. Clair County Health Department
Attn: Emergency Preparedness Division
3415 28th Street
Port Huron MI 48060
Fax: (810) 987-0630

2.) Also register online with MI Volunteer Registry www.mivolunteerregistry.org