REGISTER NOW!

Professional License: *(Please circle all that apply)*

MD-DO-DDS-DVM-RPh-RN-LPN-EMT Other _____

Name: _____
First Middle Initial Last

Address: _____

City, State & Zip: _____

County:_____ Day Phone:_____ Evening Phone: _____

Fax: _____ Best time to call _____

E-mail: _____

Gender: ☐ Male ☐ Female Are you a veteran? ☐ Yes ☐ No Date of Birth: _____

Medical Profession: _____ Specialty: _____

License Number: _____ License Expiration Date: _____

Emergency Contact Name: _____

Em. Contact Number:_____ Em. Contact Relationship: _____

I understand that by voluntarily providing my information to the Logan County Citizen Corps and the Logan County Medical Reserve Corps. I am indicating a willingness to volunteer during a governmentally declared emergency that requires assistance from the medical community. Registering with the Logan County Citizen Corps and the Logan County Medical Reserve Corps is not a substitute for the appropriate professional license to practice in Ohio. I understand that it is my responsibility to properly maintain my professional license in good standing and that an Ohio license in good standing and participating in any required training or education are prerequisites to volunteering. I hereby certify and affirm all the information I have provided is true and accurate to the best of my knowledge. I also acknowledge that the Logan County Citizen Corps and the Logan County Medical Reserve Corps may verify the information I have provided as a part of the volunteering process.

Signature _____ Date _____

Return this form to:
Marsha Bowsher, Coordinator
Logan County Medical Reserve Corps
1855 St. Rt. 47 West
Bellefontaine, OH 43311

Personal contact information is for the exclusive use of the Logan County Medical Reserve Corps.