PIERCE COUNTY MEDICAL RESERVE CORPS –
EXPLORER POST #647

RETURNING
MEDICAL EXPLORERS
APPLICATON

Our Best Today for a Better Tomorrow

Returning Application Due Date:
July 31st, 2018

medical reserve corps
Pierce County
Prepared, Effective, Responsive, Competent

MEDICAL EXPLORERS
Pierce County Medical Reserve Corps
3629 S. D Street
Tacoma, WA 98418
If you have specific questions related to the application process you may email mrc@tpchd.org
http://piercecountymrc.org/?page_id=273

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Medical Explorers

Returning Application

Please complete and turn in the Returning Application on p. 4-10 for review.

Returning Application due date is July 31th, 2018

Returning Application Checklist:

- ☐ Returning General Application (p. 3)
- ☐ Additional/Updated Immunization Record (Copy of your school record) (p. 4)
- ☐ Consent to Participate (p. 5)
- ☐ Consent for Photo and Media Release (p. 6)
- ☐ Confidentiality Agreement (p. 7)
- ☐ Signature on all documents
- ☐ $25 Reapplication Fee

Reapplication Fee

Reapplication fee is $25.00. Make check or money order payable to: Pierce County Medical Reserve Corps-Explorers (PCMRC-E) Post #647. Attach check or money order to this application.

Orientation

- Once your application has been reviewed and accepted, you will be contacted to confirm the orientation date.
- Mandatory attendance at a volunteer orientation is required.

Please Print out and Sign all Documents and attach all the requested forms.

Submit application to:

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Returning Medical Explorer General Application

(Please legibly print all responses)

Full Name	Date of Birth MM/DD/YYY	Male	Female

Address					
City/Zip		Preferred Phone		Cell Phone	
Preferred Email					
Grade in Fall 2018		School Name:			

In Case of Emergency Please notify (Parent/Guardian – Local area only)			
Name		Relationship	
Preferred Phone		Cell Phone	
Preferred Email			

Who referred you to the Pierce County Medical Explorer program? Please circle **one**.				
Self-Referred	Relative	Teacher	School Counselor	Friend
School Nurse	Poster	Website	Other:	

Volunteer Experience 2018

Volunteer Activity			
For Whom/Which Agency		Number of Volunteer Hours	

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PLEASE ATTACH THE FOLLOWING TO YOUR APPLICATION:

☐ **Additional Immunization Acquired**
- Submit a copy of your immunization record with the application if additional immunizations have been acquired.

Please print and sign all documents and attach all requested forms.

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Medical Explorer Consent to Participate

If accepted as a Medical Reserve Corps volunteer and/or Medical Explorer, I agree that:

- ☐ I shall hold as absolutely confidential all information, whether oral or written, that I may obtain, directly or indirectly, through my participation in the Medical Reserve Corps/Medical Explorer Scouts concerning it or partner organization/agency operations, patients, visitors, physicians, and other personnel. Additionally, I will not attempt to take unauthorized photographs or solicit an autograph.
- ☐ My services are donated to the Medical Reserve Corps without expectation of compensation or future employment and are given for educational reasons. I realize I am never required to perform any service, which I am uncomfortable doing, or for which I have not been properly trained.
- ☐ I shall not sell or attempt to sell goods or services, require contributions, or solicit persons to sign or distribute political petitions to PCMRC/Medical Explorer Scout members.
- ☐ Immunization for MRC/Medical Scout Troop members under the age of 18 must be current and meet requirements for high school students in Washington State.
- ☐ I shall report on time and conduct myself with dignity, courtesy, and consideration of others. I understand that my appearance while on duty must be neat and clean. I shall wear the uniform designated by the Medical Reserve Corps (for MRC Youth Members) designated by MRC Leadership, and Medical Explorer Scout post leadership along with my name badge while on duty at all times.
- ☐ I shall resolve all problems related to my Medical Reserve Corps activity with adult MRC advisors (Medical Explorer Scout Post members shall resolve issues with Post advisors).
- ☐ I shall at all times uphold the philosophy and standards of the Medical Reserve Corps and comply with all policies, rules, and regulations of Medical Reserve Corps.

<u>Pierce County Medical Explorer Post Members</u>

In addition to the above listed rules and requirements I shall:

- ☐ Make my best effort to fulfill my commitment to the Medical Reserve Corps by attending all sessions, and **not have more than two absences** from regular post meetings.
- ☐ Provide **10 hours of volunteer service** to the Medical Reserve Corps in support of community events/activities.
- ☐ Uphold the philosophy and standards of PCMRC and comply with all policies, rules, and regulations of PCMRC and MRC Medical Explorer Scout program.

I understand that PCMRC reserves the right to terminate my membership status with the MRC Medical Explorer Scout program as a result of:

- ✓ Failure to comply with PCMRC policies, rules, and regulations
- ✓ Two unexcused absences
- ✓ Any other circumstances which, in the judgement of the adult Post Advisor would make my continued service contrary to my best interests or those of the PCMRC.

I have read and understand the contents of this form. If accepted as a Medical Reserve Corps Volunteer participant and/or Medical Reserve Corps Medical Explorer, I agree to follow all of the above provisions.

_____ _____

Medical Reserve Corps Candidate and/or Medical Explorer Signature **Date**

I agree to my child's participation in the Pierce County Medical Reserve Corps and/or Medical Explorer Program.

_____ _____

MRC Candidate and/or Medical Explorer Parent/Guardian Signature **Date**

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Medical Explorers

Consent for Photo and Media Release

I, _____, hereby grant to the Medical Reserve Corps, and others specifically authorized by the Medical Reserve Corps, the irrevocable right to take, record, publish, broadcast, transmit, use, duplicate, license, display, distribute (including to the general public), or otherwise use in any manner the Medical Reserve Corps deems appropriate (including, but not limited to, display to the general public on the Worldwide Web) the name, voice, picture, portrait and likeness, and any photographs/ illustrations/images/audiotape/videotape/interviews/texts (collectively "Materials") of _____taken or recorded on or before the date I sign this Consent for release.

I agree that all copyright, trademark, right of publicity, and other proprietary and legal rights in the Materials are irrevocably assigned to and vested in the Medical Reserve Corps exclusively, and that I shall receive no royalties or other compensation or consideration for use of the Materials or for signing this Consent for Release, except that I agree to this release in part for the purpose of assisting Medical Reserve Corps in its role of disseminating health information to the public and to the health professions. I understand that the Medical Reserve Corps is not obligated to use any of the Materials.

I also released the Medical Reserve Corps, its affiliates, subsidiaries, directors, officers and employees from any and all liabilities that may arise from the use of the Materials.

I have read this Consent for Photo and Media Release, have been given an opportunity to ask questions about it, and I understand the contents.

I have verified the spelling of my name, and the accuracy of the information provided by the Medical Reserve Corps.

Signature_____ Date_____

Mailing address_____

City/State/Zip Code_____

Daytime Telephone No._____

If subject of material is a minor, signature of parent or guardian is required.
Signature_____ Date_____

Relationship_____

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Confidentiality Agreement

I understand that I may have access to confidential patient information and confidential information about the business and financial interests of Tacoma-Pierce County Health Department (referred to as "Confidential Information" in this Agreement). I understand that Confidential Information is protected in every form, such as written records and correspondence, oral communications, and computer programs and applications.

I agree to comply with all existing and future Pierce County Medical Reserve Corps policies and procedures to protect the confidentiality of Confidential Information. I agree not to use, copy, make notes regarding, remove, release, or disclose Confidential Information, unless it is permitted by Pierce County Medical Reserve Corps policy.

I agree not to share or release any authentication code or device, password, key card, or identification badge to any other person, and I agree not to use or release anyone else's authentication code or device, password, key card, or identification badge. I agree not to allow any other person, except those authorized by Pierce County Medical Reserve Corps, to have access to Pierce County Medical Reserve Corps' information systems under my authentication code or device, password, key card, or identification badge. I agree to notify the appropriate administrator immediately if I become aware that another person has access to my authentication code or device, password, key card, or identification badge, or otherwise has unauthorized access to Pierce County Medical Reserve Corps' information system or records.

I agree that my obligations under this Agreement continue after my time as a volunteer ends.

I agree that, in the event I breach any provision of this Agreement, Pierce County Medical Reserve Corps has the right to reprimand me or suspend or terminate my volunteer status with or without notice at the discretion of Pierce County Medical Reserve Corps and that I may be subject to penalties or liabilities under state or federal laws. I agree that, if the Pierce County Medical Reserve Corps prevails in any action to enforce this Agreement, Pierce County Medical Reserve Corps will be entitled to collect its expenses, including reasonable attorney's fees and court costs.

_____ _____

Volunteer/Medical Explorer Name Volunteer/Medical Explorer Signature

__/__/__ _____

Date Parent or Guardian if under 18 yrs of age