Dakota County Health Department

VOLUNTEER SCREENING FORM

Please return form to: DCHD
P.O. Box 155
Dakota City, NE 68731

Via Fax:
402-987-2163

For More Information:
402-987-2164
402-494-9261

Personnel Information (please print):

This information provided may be used to conduct a background check. Your information will be kept confidential

Name: First **Middle Int.** **Last**					**Date** / /
Street Address (Include Apartment #)			**Mailing Address**		
City		**State**	**Zip**	**County**	
Home # ( ) -	**Cell #** ( ) -		**Work #** ( ) -		
Email Address				Is this your **personal** or **work** email? *(please circle one)*	
*Please **circle** your preferred form of contact*	**Text**	**Call**	**Email**	**D.O.B.** / /	**Gender** _____**Male** _____**Female**
Place of Employment			**Occupation**		

Volunteer Skills: *Please check all that apply*

General Skills:

☐ Bus/Truck Driver Is your CDL license current? ___yes ___ no ☐ CPR Is your CPR Card Current? ___ yes ___ no ☐ Emergency Communications ☐ First Aid Is your First Aid Card current? ___ yes ___ no	☐ Administration/ Office Skills ☐ Animal Care/Rescue ☐ Basic Clean-up Skills ☐ Child Care ☐ Data Entry ☐ Computer Skills ☐ Construction ☐ Food Preparation ☐ Heavy Equipment Operation ☐ Amateur Radio Operator	☐ Interpreter/Translation Skills Language(s):_____ Language(s):_____ ☐ Law Enforcement ☐ Mechanical Ability ☐ Security ☐ Clergy ☐ Other: _____ _____

Training:

☐ Nebraska Psychological First Aid Date: _____ ☐ Critical Incident Stress Management Basic (CISM) Date: _____ ☐ Critical Incident Stress Management Advanced Date: _____ ☐ American Red Cross Disaster Mental Health Date: _____ ☐ FEMA Crisis Counseling Grant Date: _____ ☐ Community Emergency Response Team (CERT) Date: _____	☐ National Incident Management System (NIMS) Please list all courses completed: _____ _____ _____ ☐ Advanced Disaster Life Support Date: _____ ☐ Basic Disaster Life Support Date: _____ ☐ Emergency Volunteer Center (EVC) Date:_____ ☐ Other_____

Nebraska Licenses or Certifications:

Alcohol and Drug Counselor ☐ Alcohol and Drug Counselor ☐ Provisional Alcohol and Drug Counselor **Mental Health Practice** ☐ Independent Mental Health Practitioner ☐ Marriage & Family Therapist ☐ Master Social Worker ☐ Certified Master Social Worker-CMSW ☐ Mental Health Practitioner ☐ Professional Counselor ☐ Provisional Master Social Worker ☐ Provisional Mental Health Practitioner ☐ Social Worker ☐ Supervised Marriage & Family Therapist **Psychology** ☐ Provisionally Licensed Psychologist ☐ Psychological Assistant ☐ Psychologist ☐ Psychologist Associate **Dentistry** ☐ Dental hygienist ☐ Dentist	**Emergency Medical Care** ☐ Advanced EMT ☐ Emergency Medical Responder ☐ EMT ☐ EMT Instructor ☐ First Responder ☐ Paramedic **Massage Therapy** ☐ Massage Therapist **Medicine** ☐ Osteopathic Physician & Surgeon ☐ Physician ☐ Physician Assistant **Nursing** ☐ APRN- Certified Nurse Midwife ☐ APRN- Clinical Nurse Specialist ☐ APRN- CRNA ☐ APRN- Nurse Practitioner ☐ APRN- Nurse Practitioner/Practice ☐ Certified Licensed Practical Nurse ☐ Licensed Practical Nurse ☐ Registered Nurse	**Nursing Support** ☐ Medication Aid ☐ Medication Aid- 20 Hour ☐ Medication Aid- 40 Hour ☐ Nurse Aid ☐ Nurse Aid ICF-MR Only **Pharmacy** ☐ Pharmacist ☐ Pharmacist Intern ☐ Pharmacy Technician **Physical Therapy** ☐ Physical Therapist **Veterinary Medicine** ☐ Temporary Veterinarian ☐ Veterinarian ☐ Veterinary Technician **Early Childhood** ☐ Family Child Care Home I ☐ Provisional Child Care Home I ☐ Family Child Care Home II ☐ Provisional Child Care Home II **Other:** _____ _____ _____

Please note that we will verify applicable license via DHHS website. *You may attach a copy if you would like.*

Has your professional license ever been suspended, revoked, or disciplined?	_____Yes _____No
If "Yes" please explain_____ _____ *(if you answered "yes", this will not disqualify you from service)*	
Are you board certified? YES / NO	**Do you have prescriptive authority? YES / NO**

Have you ever been convicted of a felony? ☐ No ☐ Yes	If "yes" Please explain, including dates: _____ _____

Are you willing to help or assist another volunteer organization *(that is not DCHD)*, if requested?
_____ Yes _____ No

Emergency Contact

Name	**Relationship**	**Home #** **( ) -**	**Cell #** **( ) -**

Address	**City**	**State**	**Zip**

Release of Information:

I hereby certify to the best of my knowledge, the information I have provided is accurate. I am providing my contact information to be kept confidential in the volunteer database. This database will be used in the event of a disaster and/or to promote community preparedness. I acknowledge that health department staff may need to contact me periodically to maintain the accuracy of this information, inform me of training opportunities, or to test their communication plan's effectiveness. I authorize health department staff to contact me or my emergency contact listed above, utilizing any or all of these methods, and I agree to release all of the above-named entities from liability arising from any volunteer service I may perform. I also authorize any of the entities mentioned above to conduct a background check on me with the information I have provided.

_____ _____

Signature ***Date***

_____ _____

Parent or Legal Guardian Signature (if under 18) ***Date***