Form 1

Kentucky Division of Emergency Management

WORKERS' COMPENSATION ENROLLMENT FORM

☐ New Member ☐ Updated Enrollment

____
Name (Last) (First) (Middle)

____
Street / P.O. Box / Route #

____
(City) (Zip Code) (County)

Social Security Number ______________ DOB __________

Phone: Home ______________ Work ______________

Sex ☐Male ☐ Female

Height ______ Weight _____ Hair Color ________ Eye Color _____

Emergency Services Organization Pike County Medical Reserve Corps

List any Special Training ______________________________

____

____

____

____

Are you presently any of the following?

1. Volunteer Firefighter ☐Yes ☐No 2. Auxiliary Policeman ☐Yes ☐No

3. Water Rescue Member ☐Yes ☐No 4. Cave Rescue Member ☐Yes ☐No

5. Other: ____

Signature ____

Date ______________________________

DO NOT WRITE BELOW THIS LINE

- -

Date Received in Area Office ______________________________

Form2: Sign and Return to MRC Coordinator

REQUEST FOR CONVICTION RECORDS FIRE DEPARTMENT,
AMBULANCE SERVICE, RESCUE SQUAD

Pursuant to KRS 17.167, Request is made for any record of conviction found in the files of the Kentucky centralized criminal history record information system regarding the person identified herein. This information shall be released to:

Pike County Medical Reserve Corps/ KY EM, 119 River Drive, Pikeville KY 41501; Crystald.newsome@ky.gov
Organization Name and Address

ACKNOWLEDGEMENT BY APPLICANT

I have applied for employment or a volunteer position with one of the following organizations: a paid or volunteer fire department (certified by the Commission on Fire Protection Personnel Standards and Education), an ambulance service (licensed by the Commonwealth of Kentucky), or a rescue squad (officially affiliated with a local disaster and emergency services organization or with the Division of Emergency Management). I am requesting that the Kentucky State Police provide the employer with any record of conviction found in the files of the Kentucky centralized criminal history record information system. I know that I have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the Kentucky State police and any Kentucky State Police employee(s) from any claim for damages arising from the dissemination of inaccurate information.

I have applied for a position with the above stated organization.

APPLICANT INFORMATION **(PLEASE PRINT)**

NAME: ____
Last First Middle Maiden

ADDRESS:____
Street City State Zip

SEX _______ RACE ______ DATE OF BIRTH ________________ SOC SEC NO ______________________

______________________________ ______________________________
Signature Date Witness Date

Requesting agencies should ensure that all application information is completed.

Requests should be accompanied by **two, self –addressed stamped envelopes –** one bearing the name and address of the requesting agency and the other bearing the name and address of the applicant.

RETURN THIS FORM TO:

Kentucky State Police
Criminal Identifications and Records Branch
Criminal History Dissemination Section
1250 Louisville Road
Frankfort, KY 40601

Visit us online @ http:\\kentuckystatepolice.org

Revised 10/03

FORM 3: Sign and Return to MRC Coordinator

Medical Reserve Corps
Confidentiality, Code of Conduct, Standard Operating Guidelines Certification & Photo Authorization

I, ______________________, certify that I have read & understand the Pike County MRC Standard Operating Guidelines / Team Handbook, have had the opportunity to ask questions and agree to comply with the terms set forth therein, including, but not limited to, Confidentiality & Code of Conduct. I understand this is an unpaid volunteer position. I agree that as a MRC / SERV-KY Volunteer I may not accept payment for my services and that I may incur transportation costs. I will utilize the Incident Command System and will be accountable to my supervisor / team leader during a response event.

If, for any reason, my membership ceases with the MRC, I agree to return to the MRC Coordinator any equipment issued to me for use in my volunteer service including my MRC ID badge.

I understand that photos of me may be taken during training classes, exercises and other events involving MRC for exhibits, advertisement, promotion and/or recruiting. Photos may be used, but not limited to use, in the following ways: MRC newsletter, local newspaper and/or website or in other publications. Please check the appropriate box below.

I give the Pike County Medical Reserve Corps and the Pike County Health Department permission to use my photo as stated above.

I do not give the Pike County Medical Reserve Corps or the Pike County Health Department permission to use my photo as stated above.

I understand that this signed and dated document will become a part of my volunteer file.

______________________________ ______________________________

Volunteer Signature Date

Form 4a: If appropriate, sign and return to MRC Coordinator *(see page 17-18 for more information)*

Healthcare Experience/Education Verification

It is the responsibility of the volunteer to ensure the accuracy and completion of this form and to return this completed form to the MRC Coordinator upon its completion. Failure to comply will result in the volunteer being moved to a Non-Medical Group in the MRC.

I, ________________________________, consent to the release of information pertaining to my
Print Name

Healthcare education/Healthcare experience at _____________________________________.
Institution Name

______________________________________ ______________________________________

Volunteer Signature Date

For Agencies to Complete

____________________________________, is/was an employee/student in good standing at
Print Name

_____________________________________, in the capacity of a
Place of Employment/School Name

_____________________________________.
Position/Student

__________________________________ __________________________________

Print Name/Title of Verifying Person Institution Name

__________________________________ __________________________________

Signature Date

Contact Person:____________________________ Fax Number/Email:_____________________________
Phone Number:______________________________

Please return completed form to:

Crystal Newsome
Fax: 606-437-5512
119 River Drive
Pikeville, KY 41501

Form 4b: If appropriate, sign and return to MRC Coordinator ***(see page 17-18 for more information)***

Hospital/Clinical Privilege Verification Form

To be completed by potential volunteer

I, ____________________________________, consent to the release of my hospital/clinically
Print Name
active privilege information to the Pike County Medical Reserve Corps. This includes my

privilege effective date and current work status. I extend absolute

immunity to, and release from any and all liability, _____________________ and its authorized
place of employment
representative to release the information requested.

Please provide contact information for the verifying authority at the agency where you hold privileges.
Contact Person:_______________________ Fax Number/Email:_________________________
Phone Number:____________________________
If affiliated with another group in K HELPS, please list name of group here ____________. To avoid duplication of credentialing, signature of this form will also allow sharing of information between groups. In addition, assuming the continued involvement with the MRC, this document will be utilized on an annual basis to re-verify privileges.

____________________________________ ____________________________________
Volunteer Signature Employee number or Date of Birth

____
Date

To be completed by verifying authority
___________________________, has active hospital/clinical privileges at
Print Name
__________________________ to practice as a __________________________. Privileges are
place of employment Provider Type
active and in good standing since ___________________.
Effective Date

________________________________ ______________________________
Signature of Verifying Person Date

Please return completed form to:
Crystal Newsome Fax: 606-353-6818
119 River Drive; Pikeville, KY 41501

Form 5: Complete and Return to MRC Coordinator

K HELPS MRC ID Badge

The ID Badge will be issued after the K HELPS applicant completes & submits to the local MRC Coordinator all required forms from the MRC Standard Operating Guidelines / Team Handbook and clears the criminal record check. The following information will be needed to make the ID badge.

PLEASE PRINT INFORMATION LEGIBLY AS YOU WISH IT TO APPEAR ON THE CARD

First Name: ________________________________

Last Name:__________________________________

Medical Credentials: (ex. RN, MD, DVM, etc)

____

Affiliation: ***(see "for office use" box)***

Agency: Pike CO HD

K HELPS User Name (Identifier):_________________________

Issuer ID: Pike Co Health Dept

For Office Use:

Circle One:
SERV or MRC

○ **Medical Credential Level 1 2 3 4**

○ **NonMedical**

Date ID Issued:________________

ID Expiration Date:____________

Medical Conditions, Allergies, Etc. (be specific regarding allergies or medical conditions. This information will be used to guide your treatment should you require medical assistance during a MRC activity or response)____

____

Date of Birth:____________________

Eye Color:______________________

Hair Color:_____________________

Height (in inches):_______________