

Confidential, to be used by Medical Reserve Corps only.

PLEASE PRINT

Name _____
FIRST LAST DEGREE

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____
AREA CODE AREA CODE

Work Phone _____ Fax _____

E-mail (Home) _____ (Work) _____

MEDICAL SPECIALTY Please indicate specialty/subspecialty as appropriate:

- Physician
- Registered Nurse
- Nurse Practitioner
- Physician Assistant
- Pharmacist
- Pharmacist Tech
- LPN
- Mental Health Professional
- Clergy (Denomination) _____
- Other _____

NY LICENSE # _____

RELEVANT EXPERIENCES (optional) _____

PLEASE MAIL OR FAX THIS FORM TO:

Jay M. Scott
SUNY Upstate Medical University
750 East Adams Street
Syracuse NY 13210
Fax: 315-464-6220

Volunteer information will be stored in a secure database and used exclusively to meet Medical Reserve Corps and Public Health requirements. The information may be used for newsletter distribution, activations, license verification and reports.

SIGNATURE _____ **DATE** _____