MEDICAL RESERVE CORPS TRAINING RECORD

COURSE RECOMMENDATIONS	HOURS	DATE of EXPIRATION
MRC Orientation/Meetings		
AED		
First Aid/CPR		
Universal Precautions		
NIMS 700 /ICS 100		
Disaster Exercise or Drill (4 hours per year)		
OTHER ICS		

Emd-024 (7/00) (BACK)

PLEASE COMPLETE THE HIGHLIGTED AREAS

MEDICAL RESERVE CORPS REGISTRATION CARD – DEM

Jurisdiction: **Snohomish County Medical Reserve Corps**				Issue Date:	Registration Number
Name (Last):		(First):	(Middle):		
Address 1: Home				PHOTOGRAPH	
Address 2: Work					
City:		State:	Zip Code:		
Driver's License No.:	Date of Birth:	Blood Type:	Sex (M-F):		
Height:	Weight:	Color Eyes:	Color Hair:		
Physical Limitations(If any):		Medical Specialty:			
Home Phone: Cell Phone:		Work Telephone: Pager/2Way:		**- In Case of Emergency - Please Notify:**	
I certify that the information on this card is true and correct to my best knowledge and belief.					
Emergency Worker Signature: **Email Address:**			Date of Signature:	Name:	
MRC Worker Assignment : 10				Telephone Number with Area Code:	
Authorizing Signature:	Local Jurisdiction:		Date of Signature:	Relation to Emergency Worker:	

Emd-024 (7/00) (FRONT)

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Administration Division

CONFIDENTIAL

Applicant Disclosure and Authorization for Background Inquiry

You are applying for an appointment to a position or a volunteer opportunity with Snohomish Health District that will or may have unsupervised access to children under sixteen years of age or developmentally disabled persons or vulnerable adults. As such, and pursuant to RCW 43.43.830, applicants must provide a disclosure statement of certain civil adjudications, conviction records of crimes against persons and disciplinary board final decisions prior to appointment at Snohomish Health District.

The Snohomish Health District will make background inquiries of the above noted disclosures. Such inquiries may be made to State and/or Federal law agencies. Information obtained from the disclosure statement or from the background inquiries will not necessarily preclude appointment, but will be considered in determining the applicant's character, suitability and competence for the position applied for and may result in denial of appointment.

If you wish to be considered for appointment, you must complete and sign this *Application Disclosure and Authorization for Background Inquiry* form. Failure to complete and sign this form will disqualify you from Snohomish Health District appointment. The information provided on this form will only be considered if you are referred for an interview.

Please type or print:

Applicant Last Name:	First Name:	M.I.:
Alias/Maiden Name:		
Date of Birth:	Race:	Sex ☐ Male ☐ Female
Driver's License Number:		State:

Please answer Yes or No to each listed item below. If you answer Yes to any item, explain in the area provided or attach additional sheets indicating the charge or finding, date, court(s), and state involved.

1. Have you ever been convicted of any crimes against children or other persons?
☐ No ☐ Yes If yes, explain:

2. Have you ever been convicted of crimes related to the financial exploitation as defined in RCW 74.34.020?
☐ No ☐ Yes If yes, explain:

3. Have you ever been found in any dependency action under RCW 13.34.030 (2)(b) to have sexually assaulted or exploited any minor, or have physically abused any minor?
☐ No ☐ Yes If yes, explain:

4. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disable person or to have abused or financially exploited any vulnerable adult or found by a court in a protection proceeding under RCW 74.34, to have abused or financially exploited a vulnerable adult?
☐ No ☐ Yes If yes, explain:

I swear, under penalty or perjury that the above information is correct:

Applicant Signature: _____ **Date:** _____

3020 Rucker Avenue, Suite 306 ■ Everett, WA 98201-3900 ■ ph: 425.339.8690 ■ fax: 425.339.8702

ASSURANCE OF CONFIDENTIALITY

As an employee, student, volunteer, or individual acting in any other capacity in connection with the Snohomish Health District, I_____, agree to the following:

1. I will maintain and protect the confidentiality of information I may receive or have access to within the Snohomish Health District. This information may include protected health information (PHI) relating to an individual's healthcare and the payment for that healthcare; individually identifiable health information (IIHI) relating to demographic information which could identify the individual (i.e. name, address, phone number, social security number, medical record number, account number); personnel and payroll information; and an individual's financial information.

2. I will respect an individual's right to confidentiality and not access, read, discuss or disclose PHI, IIHI or other confidential information regarding an individual whose records are maintained in any format within the Health District **unless it pertains to my specific job requirements**.

3. **I will not access the medical information of myself, family, friends, co-workers, or others I may be curious about for whom I have no job-related business to access.**

4. I will hold discussions involving an individual's confidential information in locations which assure privacy.

5. I will comply with the Health District's policy *Use and Disclosure of Client Health Information*.

6. I will safeguard my computer password, not share it with anyone, and will not post it in a public place.

7. I will log off of the computer whenever I will be away from my work area for any length of time (i.e. breaks, lunch periods).

8. I will log off of the computer at the completion of my work day and place all confidential information (i.e. papers, removable storage devices) into locking desks, file cabinets or safes.

9. I understand that my activity on SHD computers, including the electronic medical record, is logged and also routinely monitored for suspicious, unauthorized and/or unlawful access.

10. I will report violations or potential violations of this agreement to my supervisor and the privacy/security official.

11. Upon termination of my relationship with Snohomish Health District, I agree to maintain the confidentiality of any confidential information I learned during that relationship and agree to turn over any keys, access cards, or any other device that would provide access to the Health District or its information.

12. I understand that any violation of the confidentiality of an individual's information may result in disciplinary action, up to and including dismissal, or dissolution of contractual agreement. Any deliberate unauthorized disclosure of protected health information/individually identifiable health information is a federal and Washington State civil and criminal offense.

_____ _____
SIGNATURE DATE

_____ _____
SUPERVISOR/WITNESS DATE

Revised 1/2014/nb