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 Boyle 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 _____

KyEMForm 50
Revised: October 2007

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:

_____

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 and Photo Authorization

I, _____, certify that I have read and understand the Boyle 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 and 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 will 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 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 Boyle County MRC and the Boyle County Health Dept permission to use my photo as stated above.

___I do not give the Boyle County MRC or the Boyle County Health Dept 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:

Brent Blevins, ***Boyle County Medical Reserve Corps Coordinator***
Boyle County Health Department, P.O. Box 398, Danville, KY 40422
Fax: 859-236-2863

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 Boyle 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:
Brent Blevins, ***Boyle County Medical Reserve Corps Coordinator***
P.O. Box 398, Danville, KY 40422 ***Fax: 859-236-2863***

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: Boyle Co. HD

K HELPS User Name (Identifier): _____

Issuer ID: Boyle County 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): _____

BOYLE COUNTY HEALTH DEPARTMENT

18 South Third Street
P.O. Box 398
Danville, Kentucky 40423-0398

859-236-2053
FAX 859-236-2863

Preventive Health for a Better Future

Understanding of HIPAA Responsibilities

HIPAA (Health Insurance Portability & Accountability Act of 1996)

This agreement addresses Kentucky statutes, regulations and HIPAA regulations regarding but not limited to: Confidentiality, Security, and Protected Health Information.

Protected health, confidential and sensitive information is either information that is protected by law or is of such a personal nature that it must be safeguarded. I understand that all information pertaining to personal facts, medical records and any information that can be linked to a specific person through name, ID number, social security number, address or phone number is deemed confidential. There are state and federal laws and regulations that protect this information.

I understand that any patient information I may come into contact with during my visit to the Boyle County Health Department or while engaged as a volunteer is confidential. I understand that accessing or releasing confidential information and/or records to myself or to others may subject me to civil and criminal liability.

_____ _____

Signed Dated

_____

Agency/Individual Represented