



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

**VOLUNTEER APPLICATION  
FOR MASS DISTRIBUTION/ADMINISTRATION OF MEDICAL  
COUNTERMEASURES DURING A PUBLIC HEALTH EMERGENCY**

**Preliminary Screening**

1. Are you a State of New Mexico employee? \_\_\_\_\_ Y \_\_\_\_\_ N

**IF YES, do not complete the remainder of this Application as you are not eligible for volunteer services under this application process.**

2. Are you registered in the *NM MRC Serves Registry*? \_\_\_\_\_ Y \_\_\_\_\_ N

If No, are you willing to register in *NM MRC Serves*? (See explanation below.)

*NM MRC Serves* is the New Mexico registry developed under the guidelines of the U.S. Department of Health and Human Services for establishing an Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). For more information, see [www.nmserves.org](http://www.nmserves.org) and *NM MRC Serves Registry* brochure.

**NOTE: The New Mexico Department of Health (NMDOH) will utilize *NM MRC Serves* registered and approved volunteers before other non-*NM MRC Serves* registered volunteers to support NMDOH in the mass distribution/administration of medical countermeasures during a public health emergency. *NM MRC Serves* will complete an *emergency provisional volunteer registration and credentialing process* for approval of volunteers to perform volunteer services on behalf of NMDOH during the current public health emergency.**

\_\_\_\_\_ Y \_\_\_\_\_ N

**IF YES, do not complete the remainder of this Application. You will be directed to an *NM MRC Serves* representative to complete the *NM MRC Serves* registration process.**

**Personal Information**

3. Name \_\_\_\_\_  
Last First Middle

Other names you have used? \_\_\_\_\_

4. Address \_\_\_\_\_  
Street or P.O. Box

\_\_\_\_\_ City County State Zip Code

5. Gender \_\_\_\_\_ M \_\_\_\_\_ F 6. Birth Date \_\_\_\_\_

7. Height \_\_\_\_\_ 8. Weight \_\_\_\_\_ 9. Hair Color \_\_\_\_\_ 10. Eye Color \_\_\_\_\_

11. Languages Spoken/Understood \_\_\_\_\_

**Contact/Emergency Contact Information**

12. Your Telephone Number(s) \_\_\_\_\_  
Home Office Cell

13. Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_  
Home Office Cell

Address \_\_\_\_\_  
Street or P.O. Box City County State Zip Code

Alternate Emergency Contact Name \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_  
Home Office Cell

**Education (Post High School)**

14. Institution Name \_\_\_\_\_

Address \_\_\_\_\_  
City State

Degree Type \_\_\_\_\_ Conferred Date \_\_\_\_\_

**Employment Information**

15. Employer Name \_\_\_\_\_

Address \_\_\_\_\_  
Street or P.O. Box      City      County      State      Zip Code

Telephone Number \_\_\_\_\_

16. Primary Profession \_\_\_\_\_  
Are you retired from this Profession? \_\_\_\_\_ Y \_\_\_\_\_ N

17. Other Employment Experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Unencumbered License(s) (If Applicable)**

18. License Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_  
List Additional License(s): \_\_\_\_\_

**Certification(s)/Registration(s)**

19. Do you have any certifications? \_\_\_\_\_ Y \_\_\_\_\_ N  
If Yes, Certifying Institution Name \_\_\_\_\_  
Certification Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Clinical Status**

20. Are you clinically active in any setting other than a hospital? \_\_\_\_\_ Y \_\_\_\_\_ N

**Training**

21. Would you be available for NMDOH "Just-in-Time Training"? \_\_\_\_\_ Y \_\_\_\_\_ N

22. Have you had Emergency Preparedness Training? \_\_\_\_\_ Y \_\_\_\_\_ N

If Yes, Course Title \_\_\_\_\_  
Institution Name \_\_\_\_\_  
Completion Date \_\_\_\_\_ Certification Expiration Date \_\_\_\_\_

23. Have you had National Incident Management System (NIMS) Training?  
\_\_\_\_\_ Y \_\_\_\_\_ N ICS Course Number(s) \_\_\_\_\_

24. Do you have any other special skills that may be valuable during an emergency?  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Preparedness Affiliations**

25. List any emergency preparedness affiliations to which you belong, including local, state, federal entities (e.g., American Red Cross; Salvation Army; Cities Readiness Initiative Volunteer; Medical Reserve Corps; City, County or Tribal Emergency Management; National Disaster Medical System, etc.):

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**Deployment Preferences**

26. Travel Distance (in miles) \_\_\_\_\_

27. Deployment Duration (in days) \_\_\_\_\_

**Authorizations, Affirmations and Signature**

I hereby give my consent to the NMDOH to use my information, as deemed necessary, to process my Volunteer Application for approval of me for volunteer services during this public health emergency, or other NMDOH volunteer efforts.

\_\_\_\_\_ Y \_\_\_\_\_ N

I hereby acknowledge and affirm that all statements made in this Volunteer Application are true.

\_\_\_\_\_ Y \_\_\_\_\_ N

I hereby give the NMDOH consent to perform reference and background checks.

\_\_\_\_\_ Y \_\_\_\_\_ N

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**Signature of Volunteer Applicant**

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**Date**