

SPECIALIZED MEDICAL ASSISTANCE RESPONSE TEAM – S.M.A.R.T. ENROLLMENT FORM

PLEASE PRINT

Date: _____

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Primary E-Mail: _____ Alt E-Mail: _____

Date of Birth: _____ Citizenship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Employer: _____

Job Title: _____

_____ **Non – Medical Volunteer**

_____ **Medical Volunteer (check if applicable)**

_____ Physician Physician Specialty: _____

_____ Physician's Assistant

_____ Veterinarian _____ Veterinarian Technician

_____ Dentist _____ Dental Assistant

_____ Nurse _____ RN _____ LPN _____ Practitioner _____ PHN

_____ Mental Health Provider _____ Social Worker _____ Psychologist _____ Canine Therapy

_____ Pharmacist _____ Pharmacy Technician

_____ Firefighter

_____ EMT _____ Basic _____ Intermediate _____ Paramedic

License Number: _____ License Expiration Date: _____

_____ Student _____ Retiree

Second Language _____ Special Skills: _____

_____ **Yes, I am willing to deploy outside of Erie County, New York**

How did you hear about us? _____

Please fax this form to: Erie County Public Health Emergency Preparedness @ 716-858-7121

Email to: ECMRC@erie.gov

or mail to: Erie County Health Department, S.M.A.R.T., Rath Building, 95 Franklin St. Room 931, Buffalo, N.Y. 14202