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