

St. Anna Episcopal Church's Medical Mission

Out-of-state SOCIAL WORKER VOLONTEER Forms

INSTRUCTIONS: Return the attached forms and copies / documentation of the items listed below to –

Diana Meyers
1313 Esplanade Ave.
New Orleans, LA 70116

Or Fax them to: (504) 947-2122

Please allow a minimum of 2 weeks for verification of licensure before we can allow you to work with us. We will contact you as soon as the verification is complete to set dates / times for your work.

To contact Diana with questions, please call (504) 947-2121.

We can't thank you enough for your willingness to work with us to serve the people of New Orleans.

Forms NOT Included in this Packet:

- Out-of-State Volunteer Intake Form
- Volunteer Medical Information Form
- Out-of-State Conditions of Participation Form
- Episcopal Diocese of Louisiana – Volunteer Agreement & Release
- Liability Release and Indemnity Form – St. Anna's Medical Mission

Forms Included in this Packet:

- Social Workers ESAR – VHP Form

Other Documentation Required:

- Copy of your current Social Worker's License
- Copy of a government issued photo ID (driver's license or passport)
- Copy of recent (within 1 year) TB skin test (if available)
- Copy of your Health Insurance Cards
- Reference Letter re: your work and appropriateness for this Mission

8919 World Ministry Avenue, Ste. B
 Baton Rouge, LA 70810
 Number _____

Credential Level
 Volunteer

Email: mmstarks@dhh.la.gov Telephone: (225) 763-3566 Fax: (225) 765-2794 _____

Behavioral Health Specialists

Emergency Systems for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP) Registration Form

IDENTIFICATION INFORMATION: (Please print or type ALL information)					
Legal Name					
Last:		First:		Middle:	
Street Address: _____					
City:		State:		Zip Code:	
Home Telephone Number:		Cell Telephone Number:		Pager:	
Fax Number:		E-mail Address:			
Employer: _____					
Street Address: _____					
City:		State:		Zip Code:	
Do you practice active clinical work?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Date in which you started practicing active clinical work:	

Type of setting in which health volunteer practices his/her clinical work:					
<input type="checkbox"/> Hospital <input type="checkbox"/> Private or Group Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Public Health					
Name of Supervisor: _____					
Work Telephone Number: _____					
Military Experience:		<input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security #:	
Date of Birth:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height (Feet/Inches):	
Weight:		Color of Hair:		Color of Eyes:	
Do you speak any language other than English fluently?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what other language do you speak?				_____	
Have you ever had a civil or criminal conviction in federal or state court, or had any adverse federal or State licensing actions, or been excluded from participation in federal or state health care programs? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please list previous work experience: <input type="checkbox"/> Hospital <input type="checkbox"/> Private or Group Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Public Health					
Name of Supervisor: _____					
Name of Organization: _____					
City: _____ State: _____					
Dates of Employment (Month/Year): ____ / ____ to ____ / ____					
EDUCATIONAL INSTITUTIONS					
Name of Educational Institution		City/State		Degree and Date Conferred	

Return Registration to:

Office Use Only

Center for Community Preparedness
ESAR-VHP Program
 8919 World Ministry Avenue, Ste. B
 Baton Rouge, LA 70810
 Number _____

License(s) Verified
 Forwarded to Region
 Credential Level
 Volunteer

Email: mmstarks@dhh.la.gov Telephone: (225) 763-3566 Fax: (225) 765-2794

CERTIFICATIONS: *(Please list all certifications awarded by the National Association of Social Workers or American Boards of Professional Psychology specializations, date conferred and expiration date.)*

OCCUPATION:		STATE LICENSE NUMBER: _____
<input type="checkbox"/> Marriage/Family Therapist	<input type="checkbox"/> Substance Abuse Social Worker	STATE OF LICENSE: _____
<input type="checkbox"/> Medical/Public Health Social Worker	<input type="checkbox"/> Psychologist	EXPIRATION DATE: _____
<input type="checkbox"/> Mental Health Social Worker	<input type="checkbox"/> Mental Health Counselor	

ARE LICENSE/LICENSSES IN GOOD STANDING? Yes No

ARE THERE ANY ADVERSE ACTIONS ASSOCIATED WITH YOUR LICENSE? Yes No

IF APPLICABLE, DID YOU SUCCESSFULLY COMPLETE THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY EXAMINATION? Yes No

PROFESSIONAL TRAININGS IN EMERGENCY PREPAREDNESS/RESPONSE *(Please list all courses and dates taken)*

Course	Date Taken

CREDENTIALS: *(Please list all credentials held or awarded by the National Association of Social Workers and expiration date.)*

EMERGENCY CONTACT NAME: _____

CONTACT NUMBER: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SPECIFIC PREFERENCE FOR DEPLOYMENT: Local State Out-of-State

Distance in miles from legal residence that volunteer is willing to be deployed:

0-25 26-50 51-100 101-500 >500

In the event of a declared national emergency, would you consider volunteering to work under the auspices of the federal government? If you check yes, in the event of a national emergency, the information you provide will be made available to the federal government upon its requests. Yes No

By signing and dating this form you acknowledge that the information provided is accurate and thereby, authorize the State of Louisiana to collect, use and maintain the personal information provided. The volunteer also consents to allow the State of Louisiana to perform reference and background checks.

SIGNATURE _____
DATE