

Appendix C

**ODMT Membership Application**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Work Phone \_\_\_\_\_

Paging Company \_\_\_\_\_ City \_\_\_\_\_ Pager \_\_\_\_\_

Medical License/Certificate Number \_\_\_\_\_ State \_\_\_\_\_

Specialty \_\_\_\_\_

DEA (if applicable) \_\_\_\_\_

Other current certification: (ie: BLS, ACLS)

\_\_\_\_\_

Passport No. \_\_\_\_\_ Expiration \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Citizenship \_\_\_\_\_

Motivation and Experience

Why are you applying for Oregon Disaster Medical Team?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you interested in opportunities for service (circle): Only in Oregon  
National Overseas

Do you have disaster/relief team experience (ie: DMAT, NW Medical Teams,  
Red Cross)

\_\_\_\_\_  
Language fluency: Written \_\_\_\_\_ Spoken \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Position \_\_\_\_\_

Is your employer aware of your interest in the disaster team? Yes No

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Position \_\_\_\_\_

Is your employer aware of your interest in the disaster team? Yes No

Special skills or contacts that you are willing to share with the team?  
(i.e.: Web design, HAM radio, fundraising, accounting, logistics,  
storage, rescue)

\_\_\_\_\_

Emergency Contacts

Name \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

References

Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Health

Describe your health status (ie: excellent, fair) \_\_\_\_\_

Describe any medical limitations \_\_\_\_\_  
\_\_\_\_\_

Do you regularly take any prescription medication that would be required on deployment? Yes; please list \_\_\_\_\_ No

Do you have any medical or mental health conditions that may affect your ability to perform your duties in austere conditions on a disaster deployment? Yes. If yes, you will require a physician's release on file. No

Immunizations

	Most Recent Date	Mechanism (shot, titer, disease)
REQUIRED:		
Diphtheria/Tetanus within 5 years	_____	_____
Polio primary series and booster	_____	_____
Measles 2 doses	_____	_____
Mumps 1 dose	_____	_____
Rubella 1 dose	_____	_____
Hepatitis B 3 doses	_____	_____
RECOMMENDED:		
Hepatitis A 2 doses	_____	_____
Polio 1 dose as adult	_____	_____
Yellow Fever 1 dose	_____	_____
Typhoid within 5 years	_____	_____
Other Immunizations may be recommended at the time of specific deployments.		

(Attach additional or continued information to a separate sheet)

Declaration

I affirm that all statements that I have made in my application are accurate.

I have read the team handbook and agree to follow the ODMT bylaws. I understand that a membership fee will be due annually and that I am responsible for the purchase and maintenance of personal equipment.

I have an active license to practice my medical specialty. I am required to notify ODMT immediately if my license is suspended, revoked, limited or voluntarily relinquished.

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Signature

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Date