SEDGWICK COUNTY, Kansas
medical reserve corps

Please print

Volunteer Information Update

Please print

DATE OF BIRTH FOR VERIFICATION*:** _____ ☐ ***OPTIONAL: **Vaccination update** (at bottom)

☐ **Change Name** ☐ **Change Address** ☐ **Change phone** ☐ **Change Email** ☐ **Add Email**

☐ **Change Employer** ☐ **Change Drivers License Number** ☐ **Change SSN** ☐ _____

☐ **Licensure Addition** ☐ **Licensure Removal** ☐ **Medical Licensure Restriction** ☐ _____

Name on MRC File: _____
LAST *FIRST* *MIDDLE*

Name Change: _____
LAST *FIRST* *MIDDLE*

New Address: _____
HOUSE/APT # *STREET* *CITY* *COUNTY*

New Phone

_____ _____ _____ _____
NEW HOME PHONE *NEW CELL PHONE* *NEW ALTERNATIVE PHONE* *NEW WORK PHONE (NO EXT. # PLEASE)*

New Email: _____

Alternate Email: _____

New Employer: _____
NAME *ADDRESS* *POSITION* *SHIFT*

Drivers License Number: _____ Exp: _____

Social Security Number: _____ Date: _____

Licensure Addition: _____
TYPE *THROUGH* *EFFECTIVE DATE*

Licensure Addition: _____
TYPE *THROUGH* *EFFECTIVE DATE*

Licensure Removal: _____
TYPE *THROUGH* *EFFECTIVE DATE* *CAUSE*

Licensure Removal: _____
TYPE *THROUGH* *EFFECTIVE DATE* *CAUSE*

Licensure Restriction: _____
TYPE *THROUGH* *EFFECTIVE DATE* *CAUSE*

Licensure Restriction: _____
TYPE *THROUGH* *EFFECTIVE DATE* *CAUSE*

OPTIONAL INFORMATION

YES	NO	*Vaccination*	*Date*		
☐	☐	Last Td (tetanus)	_____		
☐	☐	PPD	_____		
☐	☐	Hepatitis B Series	_____	_____	_____
☐	☐	Hepatitis A Series	_____	_____	
		Or			
☐	☐	Hepatitis A/B Combo	_____	_____	_____

Please submit completed form:

By mail: Medical Reserve Corps 1530 S. Oliver, Suite130 Wichita, Kansas 67218
Fax: (316) 660-5550 ***or*** **Email:** mrc@sedgwick.gov