

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
1538 EAST PARHAM ROAD
RICHMOND, VIRGINIA 23228

**ESF-8 TEAMS
PERSONNEL APPLICATION**
(This form may be used as a personnel update form)

Please Print or Type

Date Form Completed: _____

Name: _____ DOB: ____/____/____

Social Security Number: _____

Address: _____

(City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Pager #: _____ Cellular Phone #: _____

E-mail Address: _____

Agency Affiliation: _____

Education: (circle highest completed) *High School, Associate, Bachelor, Master, Doctorate*

Highest Medical Certification: *FR, EMT-B, EMT-ST, EMT-I, EMT-C, EMT-P, other:* _____

List the training you have completed as it relates to the team you are applying for:

List any experience in disaster response:

Dates:

_____	_____
_____	_____
_____	_____
_____	_____

AFFIDAVIT: I attest that the above information is true and correct. I understand that fraudulent entry of information will result in non-acceptance or dismissal.

Signed: _____ Date: _____

VOLUNTEERS: I apply for membership in a Virginia ESF-8 Team and offer my services to the Virginia Office of Emergency Medical Services under the provisions of the Virginia Government Volunteer Act. I certify that the statements of my experience and training are accurate, and I understand that misrepresentation of my experience, training and certification will be a bar to membership or a cause for termination of membership as applicable. I certify I am currently authorized to provide care and or assistance to the level of my current certifications. I understand I will serve as a volunteer when my ESF-8 team is activated and that reimbursement for expenses and liability coverage will be as described in the Virginia State Government Volunteer Act and the Disaster Laws of Virginia. I agree to complete such training as may be required and to properly equip myself for emergency duties. I agree to comply with Standard Operating Procedures for ESF-8 Teams as issued by the Office of Emergency Medical Services and to obey the instructions and orders of ESF-8 team officers.

Signed: _____ Date: _____

AGENCY ENDORSEMENT: I approve of this individual to serve as a member of an ESF-8 team. He or she is a currently certified provider and member in good standing of our agency as represented above.

Signed: _____ Date: _____

Agency: _____ Title: _____

ESF-8 TEAM ENDORSEMENT: This individual is accepted for membership in the ESF-8 Team named on the front of this application.

Signed: _____ Date: _____

Commander/Team Leader, ESF-8 Team: _____

OFFICE OF EMS ENDORSEMENT: _____ **APPROVED** _____ **DENIED**

Signed: _____ Date: _____