PLEASE COMPLETE THE AREAS LABELED IN RED

MEDICAL RESERVE CORPS REGISTRATION CARD - DEM#

Jurisdiction: Island County Medical Reserve Corps				Issue Date:	Registration Number:
Name (Last):		(First):	(Middle):		
Address 1:				PHOTOGRAPH	
Address 2:					
City:		State:	Zip Code:		
Driver's License No.:	Date of Birth:	Blood Type:	Sex (M-F):		
Height:	Weight:	Color Eyes:	Color Hair:		
Physical Disabilities (If any):					
Home Telephone:		Work Telephone:		- In Case of Emergency - Please Notify:	
I certify that the information on this card is true and correct to my best knowledge and belief.					
MRC Worker Signature:			Date of Signature:	Name:	
MRC Worker Assignment:				Telephone Number with Area Code:	
Authorizing Signature:	Local Jurisdiction:		Date of Signature:	Relation to Emergency Worker:	

Emd-024 (7/06) (FRONT)