Return Registration to:
Center for Community Preparedness
ESAR-VHP Program
8919 World Ministry Avenue, Ste. B
Baton Rouge, LA 70810
Email: mmstarks@dhh.la.gov
Telephone: (225) 763-3566
Fax: (225) 765-2794

Office Use Only
License(s) Verified ____________________
Forwarded to Program ____________________
Forwarded to Region ____________________
Credential Level ____________________
Volunteer Number____________________

Please direct nursing questions to:
Clair Millet, APRN, MN, CNS
Chief Public Health Nurse
Telephone: 225-763-3965
Email:cpmillet@dhh.la.gov

Louisiana Nurses in Action

Emergency Systems for Advance 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:**	

Type of setting in which health volunteer practices his/her clinical work:

☐ Hospital ☐ Private or Group Practice ☐ Clinic ☐ Public Health

Name of Supervisor:	
Work Telephone Number:	

Military Experience:	☐ Yes ☐ No			**Social Security #:**	
Date of Birth:		**Gender:**	☐ Male ☐ Female	**Height (Feet/Inches):**	
Weight:		**Color of Hair:**		**Color of Eyes:**	

Do you speak any language other than English fluently?	☐ Yes ☐ 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 participate in federal or state health care programs? ☐ Yes ☐ No

EDUCATIONAL PREPARATION: ☐ Diploma ☐ AD ☐ BSN ☐ MS ☐ MSN ☐ MN ☐Other ____________
(Check all that apply)

EDUCATIONAL INSTITUTIONS

Name of Educational Institution	City/State	Degree and Date Conferred

☐ Advanced Practice Registered Nurse ☐ NP ☐ CNM ☐ CNS ☐ Other
Specialty Area(s):____________________
Name of organization which awarded specialization: ____________________
Date certification was issued:____________________

CERTIFICATIONS: *(Please list all certification held)*

____

____

____

Check one or both boxes below: **LICENSE:** ☐ Active ☐ Retired	License No:		State of Licensure:		Expiration Date:	
LIST ANY ADDITIONAL STATE LICENSES:	License No:		State of Licensure:		Expiration Date:	

ARE LICENSE/LICENSES IN GOOD STANDING? ☐ Yes ☐ No

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

PROFESSIONAL TRAININGS IN EMERGENCY PREPAREDNESS/RESPONSE

(Please list all courses and dates taken)

Course	Date Taken

CREDENTIALS: *(Please list all credentials held)*

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**