

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](mailto: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	_____

## Medical Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

### Registration Form

IDENTIFICATION INFORMATION: <i>(Please print or type ALL information)</i>					
<b>Legal Name</b>					
<b>Last:</b>		<b>First:</b>		<b>Middle:</b>	
<b>Street Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	
<b>Home Telephone:</b>		<b>Cell Telephone:</b>		<b>Pager:</b>	
<b>Fax Number:</b>		<b>E-mail Address:</b>			
<b>Employer:</b>					
<b>Street Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	
<b>Type of setting in which health volunteer practices his/her clinical work:</b>					
<input type="checkbox"/> Hospital <input type="checkbox"/> Private or Group Practice <input type="checkbox"/> Clinic <input type="checkbox"/> Public Health					
<b>Name of Supervisor:</b>					
<b>Work Telephone Number:</b>					
<b>Military Experience:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Social Security #:</b>	
<b>Date of Birth:</b>		<b>Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Height (Feet/Inches):</b>
<b>Weight:</b>		<b>Color of Hair:</b>		<b>Color of Eyes:</b>	
<b>Do you speak any language other than English fluently?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>If yes, what other language do you speak?</b>					
<b>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 participation in federal or state health care programs?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
EDUCATIONAL INSTITUTIONS					
Name of Educational Institution	City/State	Degree and Date Conferred			
<b>Name of Supervisor at which health volunteer performed his/her residency:</b> _____					
<b>Name of Organization:</b> _____					
<b>City:</b> _____ <b>State:</b> _____					
<b>Specialization:</b> _____					
<b>Date at which health volunteer complete his/her residency:</b> ____ / ____					
<b>Number issued by Educational Commission for Foreign Medical Graduates:</b> _____ <b>Date:</b> _____					

*Please direct Medical questions to: Dr. Erin Brewer, Center Director for Community Health at 504-219-4402*

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Check one or both boxes below: <b>LICENSE:</b> <input type="checkbox"/> Active <input type="checkbox"/> Retired		<b>License No:</b> _____	<b>License Type:</b> <input type="checkbox"/> MD <input type="checkbox"/> OD	<b>State of Licensure:</b> _____	<b>Expiration Date:</b> _____
<b>DEA LICENSE NUMBER:</b> _____		<b>EXPIRATION DATE:</b> _____			
<b>ARE LICENSE/LICENCES IN GOOD STANDING?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>ARE THERE ANY ADVERSE ACTIONS ASSOCIATED WITH YOUR LICENSE?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>HAVE YOU EVER SURRENDERED OR HAD A FEDERAL CONTROLLED SUBSTANCE REGISTRATION REVOKED, SUSPENDED OR RESTRICTED?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>ABMS/AOS CERTIFICATION</b>		<b>Specialty:</b> _____ <b>Expiration Date:</b> _____ <b>Specialty:</b> _____ <b>Expiration Date:</b> _____ <b>Specialty:</b> _____ <b>Expiration Date:</b> _____			
<b>ABMS/AOA ELIGIBLE</b>		<b>Name of hospital at which the health volunteer is eligible to practice:</b> _____ <b>City:</b> _____ <b>State:</b> _____			
<b>ACTIVE CLINICAL PRACTICE</b>		<b>Name of non-hospital/hospital organization where the health volunteer practices active clinical work:</b> _____ <b>Date at which health volunteer started practicing active clinical work at non-hospital/hospital organization:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Specialties:</b> _____			
<b>PROFESSIONAL TRAININGS IN EMERGENCY PREPAREDNESS/RESPONSE</b> <i>(Please list all courses and dates taken)</i>					
<b>Course</b>			<b>Date Taken</b>		
<b>EMERGENCY CONTACT NAME:</b>					
<b>CONTACT NUMBER:</b>					
<b>ADDRESS:</b>					
<b>CITY:</b>		<b>STATE:</b>		<b>ZIP:</b>	
<b>SPECIFIC PREFERENCE FOR DEPLOYMENT:</b> <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> Out-of-State					

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**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**