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______________________________

Behavioral Health Specialists
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:		**Cell Telephone :**		**Pager:**	
Fax Number:		**E-mail Address:**			
Employer:					
Street Address:					
City:		**State:**		**Zip Code:**	

Do you practice active clinical work?	☐ Yes ☐ No	**Date in which you started practicing active clinical work:** ____________________

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 participation in federal or state health care programs? ☐ Yes ☐ No

Please list previous work experience:
☐ Hospital ☐ Private or Group Practice ☐ Clinic ☐ Public Health
Name of Supervisor:______________________________
Name of Organization:______________________________
City: ____________________ **State:**____________________
Dates of Employment (Month/Year):_____/_____ **to** _____/_____

EDUCATIONAL INSTITUTIONS

Name of Educational Institution	City/State	Degree and Date Conferred

Please direct Behavioral Health questions to: Patricia Calvin Scott, Director Medical Social Services at 504-219-4448

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CERTIFICATIONS: *(Please list all certifications awarded by the National Association of Social Workers or American Boards of Professional Psychology specializations, date conferred and expiration date.)*

____

____

OCCUPATION:
☐ Marriage/Family Therapist
☐ Medical/Public Health Social Worker
☐ Mental Health Social Worker
☐ Substance Abuse Social Worker
☐ Psychologist
☐ Mental Health Counselor

STATE LICENSE NUMBER: ________________
STATE OF LICENSE:________________
EXPIRATION DATE:________________

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

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

IF APPLICABLE, DID YOU SUCCESSFULLY COMPLETE THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY EXAMINATION? ☐ Yes ☐ No

PROFESSIONAL TRAININGS IN EMERGENCY PREPAREDNESS/RESPONSE
(Please list all courses and dates taken)

Course	Date Taken

CREDENTIALS: *(Please list all credentials held or awarded by the National Association of Social Workers and expiration date.)*

____
____
____

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**