Disaster Response - DOH Employee Team Member

This form is to be completed and taken with you to turn in at the check-in/briefing site.

Do not fill in: To be used by check-in/briefing site

Arrival date with briefing: _____/_____/_____

Departure Date with de-briefing: _____/_____/_____

Demobilization Completion Date: ____/_____/_____

Assignment:_____Lodging_____

Deployment Supervisor_____Contact Info_____

MISSION NUMBER:_____ Assigned Mission Location _____
Accounting Codes for your Mission_____

Name: _____
Last (Please use as appears on Driver's License) First

Gender: ☐ Female or ☐ Male

Home Address: _____

City: _____State: _____ ZIP: _____County:_____

Home phone: _____/_____-_____ Work phone: _____/_____-_____

Cell phone: _____/_____-_____Blackberry & DC: _____

Agency/Office: _____ Phone: _____/_____-_____

_____
Address City State ZIP

Supervisor's name: _____ Phone: _____/_____-_____

Emergency contact name: _____ Relationship: _____

Phone: _____/_____-_____ Cell: _____/_____-_____

Profession: (Check all that apply)

☐ Nurse- RN	☐ Physician	☐ Critical Care	☐ Home Health
☐ Nurse - LPN	☐ Medical other	☐ Nutritionist - WIC	☐ Environmental Health
☐ Nurse - ARNP	☐ PIO	☐ Epidemiology	☐ Other (list below)
☐ Social Worker	☐ Mental Health	☐ Pediatrics	☐ _____

License #: _____ State: _____

Assignment: _____ Lodging: _____

Foreign Language spoken: none _____ Spanish _____ Creole _____ Other (list) _____