# San Bernardino County Sheriff's Dept. Medical Reserve Corps

www.sbcms.org/mrc

## APPLICATION INTEREST FORM

**Please PRINT or TYPE All Information**

**Name:** _____
**FIRST MIDDLE LAST**

**Street Address:** _____

**City/State/Zip:** _____

**Mailing Address** ***(If different than above):*** _____

**City/State/Zip:** _____

**Email:** _____

**Home Phone:** _____ **Cell:** _____

**Work Phone:** _____ **Pager:** _____

**Social Security #** _____ **Date of Birth:** _____

**Drivers License #** _____ **State** _____ **Expires** _____

1. **Have you ever been:** **Convicted of a Felony?** **[ ] Yes [ ] No**
   **Arrested? [ ] Yes [ ] No** **Convicted of a Misdemeanor? [ ] Yes [ ] No**
2. **Have you ever been fingerprinted? [ ] Yes [ ] No**
3. **Circle highest grade completed:**
   **High School 9 10 11 12** **Professional Degree** _____
   **College: AA/AS BA/BS MA/MS** **Professional License #** _____
   **Other** _____

**I hereby authorize the San Bernardino County Sheriff's Department to conduct a background investigation concerning my work reputation, medical, physical, and criminal records, including information of a confidential or privileged nature.**

**Signature** _____ **Date** _____

**Mail or Fax to**
**San Bernardino County Sheriff Medical Reserve Corps**
**P O Box 11029 – San Bernardino, CA 92423**
**Fax No. (951)-787-8795**