

COBRA RESPONSE TEAM Application Form



Team Information:

County Name:	Date:
Team Position(s) Requested:	

Applicant Information: Please provide all information requested.

Name: (First)	(M)	(Last)	Employer:		
Home Address:			Work Address:		
City:	State:	Zip:	City:	State:	Zip:
Social Security Number:	Home Phone:	Work Phone:	Fax Number:		
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E-Mail Address:			Position/Job Title:		
Would you like to be included in a group email notification system to keep you informed of COBRA Response Team issues? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Do you have any disabilities (including special allergies or medical disabilities) which would require special assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe and indicate any special assistance required on back.					
Applicant Signature:		Date:	Supervisor's Signature:		Date:
COBRA Team Program Management Coordinator: Please review the above application and identify which team position(s) they could possibly fill.					
COBRA Program Management Coordinator's Signature:					Date:
Comments:					

Please be sure to print clearly and provide all requested information.