

2024 EDITION

THE MEDICAL RESERVE CORPS

NETWORK PROFILE

NACCHO
National Association of County & City Health Officials

medical reserve corps

“OUR MRC VOLUNTEERS REMIND ME OF THE HUMANITY THAT EXISTS IN THIS WORLD. IT’S AN HONOR TO WORK ALONGSIDE THEM.”

— JOE KALSCHEUR, UNIT LEADER, EAU CLAIRE COUNTY MRC, WISCONSIN

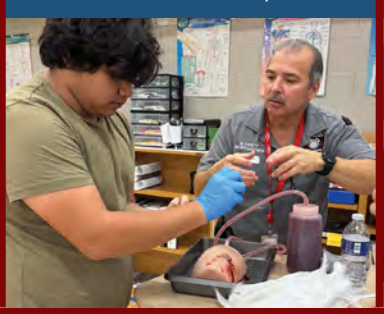
OKLAHOMA MRC



HARRIS COUNTY MRC, TX



PEARLAND AREA MRC, TX



HAMPSHIRE COUNTY MRC, MA



ON THE COVER: Collin County MRC, Texas

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NACCHO℠
National Association of County & City Health Officials

medical reserve corps

EXECUTIVE SUMMARY

The Office of Medical Reserve Corps (OMRC), housed within the Center for Preparedness at the Administration for Strategic Preparedness and Response (ASPR) of the U.S. Department of Health and Human Services (HHS), provides national-level support to the national network of Medical Reserve Corps (MRC) units. For 19 years, the Office of MRC has partnered with the National Association of County and City Health Officials (NACCHO) through a cooperative agreement to further strengthen the capacity and sustainability of MRC units nationwide.

In 2024, NACCHO conducted its sixth comprehensive survey of the MRC network. This survey assessed public health emergency preparedness and response activities from active MRC units across the U.S. This report offers a snapshot of the MRC Network, highlighting unit training, capabilities, response activities, and partnerships. It serves as a resource for policymakers, public health leaders, and MRC stakeholders to benchmark current efforts, share best practices, and inform future strategies.

HIGHLIGHTS OF THE DATA INCLUDE:

- A total of 468 units reported 201,322 volunteers across many states, with a mix of background and skills;
- Volunteers contributed 269,094 hours to support emergency and non-emergency activities;
- MRC units supported a wide range of communities according to population size, ranging from less than 10,000 residents (4%) to 1,000,000 or more residents (15%);
- Over three quarters of units (77%) have a written volunteer training plan in place;
- Three in five units (62%) reported working with other MRC units on joint trainings and exercises; and
- MRC units reported working with local emergency management (77%), local health departments (76%), and health care coalitions (59%), as response partners.

This report demonstrates that MRC volunteers are a trained and ready volunteer workforce that is uniquely positioned to support local emergency response and community preparedness. NACCHO recommends collaboration by stakeholders to better understand the complexities of interstate and intrastate volunteer deployment to respond to emergencies and build community resilience.



DUCHESS COUNTY MRC, NEW YORK

About this Report

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Finally, thank you to the 503 MRC unit leaders who provided the information that made this research possible.

"THE HEART OF OUR UNIT IS OUR VOLUNTEERS."

— ANGEL EKSTROM, UNIT LEADER, CENTRAL NEW HAMPSHIRE MRC

A Message from the Director of the Office of MRC at ASPR

TO MEDICAL RESERVE CORPS VOLUNTEERS, PARTNERS, AND SUPPORTERS



We're honored to share the new, 2024 Network Profile update on the Medical Reserve Corps. Our 2022 Network Profile celebrated 20 years of MRC service—a milestone that reminded us how far we have come. What began as a modest idea has grown into a nationwide force of dedicated volunteers committed to strengthening public health and safety.

Now, two years after that celebration, we are stronger than ever. That strength comes from you—your dedication to your communities, your belief in our mission, and your continued support of the MRC program. Your participation in our data collection efforts made this update possible. Since 2022, we have welcomed more than 40 new units—growth driven by the incredible work you are doing locally.

This past year challenged all of us: wildfires, hurricanes, heatwaves, deep freezes—and through it all, you showed up. You staffed shelters, filled sandbags, distributed water and ice, and more. You were there, ready. But your impact does not stop when the sky clears. MRC volunteers also supported concerts, festivals, and races. You prove every day that the MRC is not just about crisis response; it is about building healthier, more resilient communities all year round.

The *2024 MRC Network Profile* is an opportunity to reflect on our progress, celebrate your achievements, and look ahead. We are committed to the continued support of federal preparedness and response efforts to strengthen local public health infrastructure, and ensure MRC units have the tools they need to respond to disasters and emergencies.

What we do—saving lives, improving outcomes, and building community resilience—will continue to be an enduring mission. This Network Profile is more than a report; it is a tribute to the nationwide network we have built and the purpose we all share.

Thank you to every MRC volunteer reading this. And if you are not yet a part of a local unit, we encourage you to get involved. The MRC is nationally recognized, locally embraced, and powered by people like you—people who make the world better by showing up for their communities.

Sincerely,
Dustun Ashton
Director, Medical Reserve Corps

BACKGROUND & METHODOLOGY

Background

The Medical Reserve Corps is a national network of dedicated volunteers who support public health and emergency preparedness in communities across the United States and its territories. Established after the September 11, 2001 terror attacks, the MRC was created as a demonstration project under the George W. Bush Administration to identify, train, and organize volunteers capable of responding to both human-made and natural disasters. What began with 42 community-based units has grown into a robust network of over 700 units and over 260,000 volunteers as of August 2025.

The MRC operates through local units led by unit coordinators who align volunteer capabilities with community needs. These coordinators play a critical role in building partnerships, sustaining operations, and managing volunteer resources to ensure readiness and responsiveness. The diversity of skills and backgrounds among the MRC volunteers, unit leaders, and units enhances their abilities to address a wide range of public health initiatives and emergency response activities.

The Office of Medical Reserve Corps, housed within the Center for Preparedness at the Administration for Strategic Preparedness and Response of the U.S. Department of Health and Human Services, provides national-level support to the network. For over 19 years, the Office of MRC has partnered with the National Association of County and City Health Officials (NACCHO) through a cooperative agreement to further strengthen the capacity and sustainability of MRC units nationwide.

This report offers a snapshot of the MRC Network, highlighting unit training, capabilities, response activities, partnerships, and funding from the last year and before. It serves as a resource for policymakers, public health leaders, and MRC stakeholders to benchmark current efforts, share best practices, and inform future strategies. As the MRC continues to evolve, its commitment to community-centered preparedness and resilience remains a cornerstone of its mission.

Methodology

In 2024, NACCHO conducted its sixth comprehensive survey of the MRC network. This survey assessed public health emergency preparedness and response activities from active MRC units across the U.S. Key topics in the survey included volunteer management, training, and capabilities.

Changes to the prior years' questionnaires were considered based on question performance and topical needs. Afterwards, review of the 2024 instrument was requested from select unit leaders via NACCHO workgroups and NACCHO staff. The survey was additionally pilot tested online via Qualtrics Survey Software with 32 MRC units in December 2024 to collect feedback to improve clarity and address any concerns before finalizing for fielding.

The final survey was administered online via Qualtrics Survey Software to the remaining 732 active MRC unit leaders. Data were collected between January 2025 and April 2025. There were 503 responses from MRC units included for analyses (response rate = 68%). All questions in the survey were optional, and thus may have a lower sample size than the total number of responses.

Descriptive statistics were computed for this survey and are all unweighted. Therefore, results provided in this report are only based on the responding units, and should not be considered nationally representative across MRC units in the U.S. Additionally, this report highlights notable differences from prior surveys from 2015 to 2022, but it is important to note that analyses prior to 2022 were weighted while 2022 and onwards are unweighted estimates. Results are not tested for statistical significance, including comparisons over time.

All data in the survey used for analyses are self-reported and are not independently verified by NACCHO. Units may have provided incomplete, imperfect, or inconsistent information for various reasons. In addition, non-response bias could impact the results presented in this report. Due to rounding, some details may be lost, and some data may not sum to 100% in the figures presented in the report.

"WE'RE FOCUSING ON HELPING PEOPLE UNDERSTAND THERE'S A PLACE FOR THEM IN THE MRC."

— MELISSA SAFFOLD, UNIT LEADER, CITY OF DETROIT MRC, MICHIGAN

A History of the MRC

SINCE ITS FOUNDING MORE THAN TWO DECADES AGO, THE MRC HAS SUPPORTED COMMUNITY EMERGENCY RESPONSE AND RESILIENCE.

MRC TIMELINE



2002

Office of the Surgeon General (OSG) announces the MRC as a demonstration project; **MRC is defined as a program** for medical, public health, and other volunteers interested in public health preparedness.



2002

42 MRC **community-based units established** to uphold the principles of the MRC project, as defined by OSG.



2006

Congress passes the **Pandemic and All-Hazards Preparedness Act (PAHPA),** which formally authorizes the MRC and its network to support emergency response at all levels: Local, State, Tribal, Territorial, and Federal.



TODAY

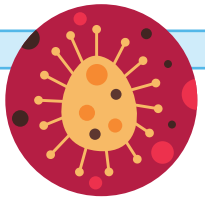
The MRC network includes **250,000+ volunteers and over 700 units** including Washington, DC, American Samoa, Commonwealth of the Northern Mariana Islands, and Puerto Rico.

MAJOR EVENTS FOR THE MRC



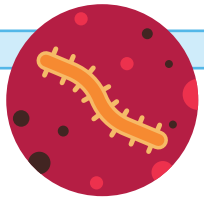
2005

More than 6,000 MRC volunteers from 150+ MRC units participate in response and recovery efforts to **Hurricanes Katrina, Rita, and Wilma.**



2009

Almost 50,000 MRC volunteers across 600 units respond to **H1N1 outbreak.** Over 2,500 separate immunization, flu prevention, and flu care activities reported.



2014

During the **domestic Ebola response,**169 units donate more than 14,000 hours across 180 activities (e.g., suspect-case screening support, health education, call centers, and providing general surveillance support).



2018

MRC volunteers in the West contribute more than 15,000 service hours **responding to wildfires** by providing medical support, psychological first aid, and animal rescue and care efforts.



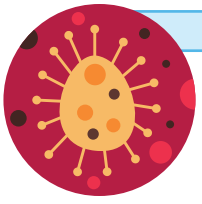
2017

Over 100 units respond to **Hurricanes Harvey, Irma, and Maria,** providing 100,000+ volunteer hours at an estimated economic value of almost $4 million.



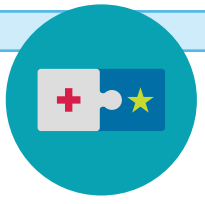
2016-17

MRC units around the country engage in response to **opioid crisis,** supporting prevention activities, training, health department support, and Harm Reduction programs to inform and aid communities affected by opioid abuse.



2020-21

Over the **COVID-19** pandemic's first two years, 80% of all MRC units provide volunteers to protect health in their communities. Volunteers devote over 3.8 million hours at an estimated economic value of $132 million.



2024

Office of the Medical Reserve Corps and the **American Red Cross** sign a formal Memorandum of Agreement (MOA), encouraging collaboration at both national and local levels to enhance community resilience.

MRC TIMELINE KEY

- NATURAL DISASTERS
- OUTBREAKS
- HUMAN INTEREST



NAUGATUCK VALLEY MRC, CONNECTICUT

MRC DEMOGRAPHICS AND COMPOSITION

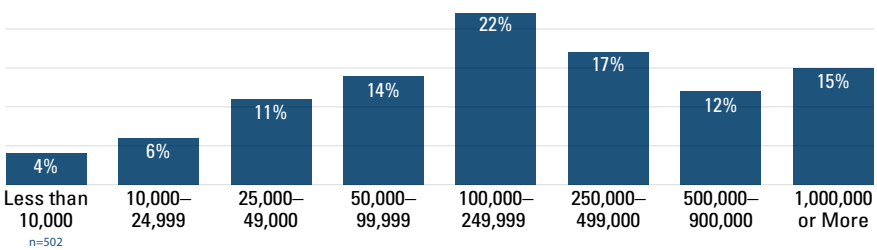
Medical Reserve Corps units are built on the support of volunteers at the community level to respond to community public health needs. In 2024, 468 units reported 201,322 volunteers across many states, with a mix of background and skills. Demographic data can support unit leaders and sponsoring agencies to ensure they are serving their community with individuals who reflect their communities. This data can help unit leaders, policy makers, and other stakeholders apply for funding and promote the MRC locally.

UNIT DEMOGRAPHICS

More than two in three responding units (68%) were affiliated with local health departments, with the remainder distributed across various other organizations. MRC units affiliated with state health departments comprised 8% of total responses, followed by units being aligned with a 501(c)(3) and emergency management organizations, each at 5%.

Among units that were not stand-alone 501(c)(3) units, more than nine in ten respondents (93%) indicated that they were integrated into their sponsoring agency's emergency preparedness and community response plan. Among responding agencies, 70% have operated under their sponsoring agency for 10 years or more, followed by 14% of respondents who listed 5–10 years, and 12% who listed 1–5 years.

FIGURE 1: *POPULATION SIZE SERVED*



KEY HIGHLIGHTS

68% OF MRC UNITS ARE HOUSED WITHIN THEIR LOCAL HEALTH DEPARTMENT.

MRC UNITS HAD AN AVERAGE OF 430 VOLUNTEERS.

In 2024, MRC units supported a wide range of communities according to population size, ranging from less than 10,000 residents (4%) to 1,000,000 or more residents (15%). FIGURE 1 (previous page). MRC units are built on the support of volunteers at the community level to respond to community public health needs. In 2024, 468 units reported 201,322 volunteers across many states, with a mix of background and skills. Demographic data can support unit leaders and sponsoring agencies to ensure they are serving their community with individuals who reflect their communities. This data can help unit leaders, policy makers, and other stakeholders apply for funding and promote the MRC locally.

MRC units served a wide range of geographies, with many serving more than one type of geography. The data reported in FIGURE 2 allowed units to select all community types served. A majority of respondents (57%) indicated that their MRC units served rural communities. Nearly half (49%) served suburban communities. Urban communities were served by 30% of responding agencies.

UNIT LEADER DEMOGRAPHICS

Unit leader demographic information provides a greater understanding of the composition of leaders within the network and the capacity of individuals to lead units. MRC unit leaders work in collaboration with their housing agency to guide units.

The number of hours per week devoted by unit leaders to MRC activities was found to vary widely across the responding units. FIGURE 3. The most reported category (27%) was fewer than 5 hours per week. An additional 20% reported spending 5–9 hours per week, while 17% indicated 10–14 hours, and 19% reported spending 15–34 hours. A smaller number, 14% of unit leaders who responded to this question, indicated they spent 35–40 hours on MRC work, and only 3% reported over 40 hours per week.

Across responding units, 16% of MRC unit leaders serve in a volunteer (unpaid) capacity, while 84% hold paid positions.

The most commonly reported age range of unit leaders was 46–65 (46%). An additional 12% identified as 66 years or older, bringing the total share of leaders aged 46 years and older to 58%. Meanwhile, 42% of leaders were reported to be under the age of 46, including 20% aged 25–35, 19% aged 36–45, and 3% aged 20–24. FIGURE 4.

More than half of unit leaders reported having a bachelor's degree (56%), while over one third (35%) reported a master's degree. Public health and emergency management or preparedness were among the most commonly reported degree fields held by MRC unit leaders.

Length of time served by unit leaders varied across responding units. FIGURE 5. Sixteen percent have held their position for less than one year. Nearly half (45%) reported the unit leader had served for between one and five years. One in five respondents (20%) reported the unit leader had served for more than 10 years.

VOLUNTEER DEMOGRAPHICS

Responding MRC units (n=468) reported an average of 430 volunteers, with the smallest unit reporting no volunteers, and the largest unit reporting 12,317 volunteers.

Among responding units that collect age characteristics of volunteers, over half of MRC volunteers were reported to be 46 and older. Volunteers under 35 made up a smaller portion, with 1% under 20, 4% aged 20–24, and 10% aged 25–35.

FIGURE 2: *MRC UNIT COMMUNITY TYPES*

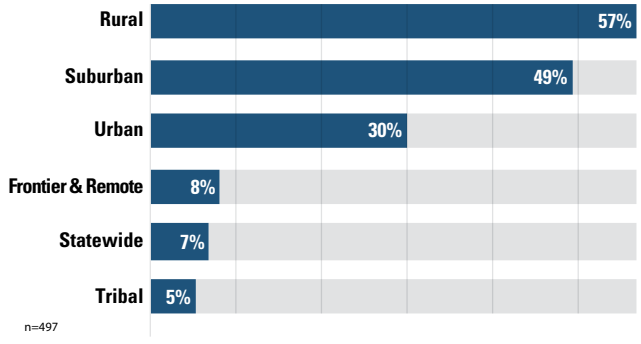


FIGURE 3: *UNIT LEADER HOURS*

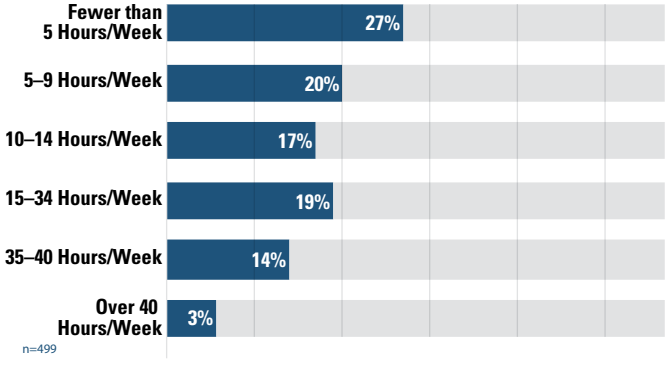


FIGURE 4: *UNIT LEADER AGES*

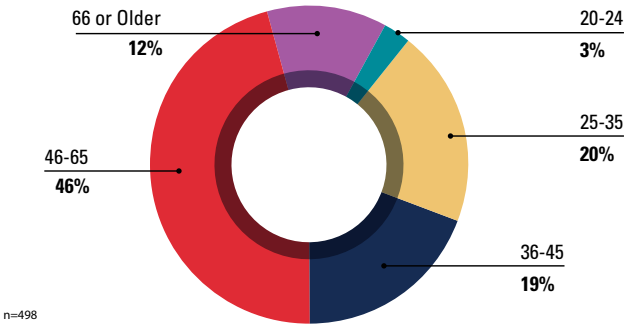


FIGURE 5: *YEARS AS A LEADER*



"MRC VOLUNTEERS HAVE A WEALTH OF SKILLS AND BACKGROUNDS WHICH MAKES US RESILIENT AS A UNIT."

— SATORIE GIBSON, UNIT COORDINATOR, PHILADELPHIA MRC, PENNSYLVANIA

Volunteers aged 36–45 accounted for 13% of volunteers. The age of 21% of volunteers was unknown. FIGURE 6.

Of responding units, almost one in three MRC volunteers (31%) were classified as non-public health/non-medical (General Support). FIGURE 7. Registered Nurses accounted for 22%, followed by Other Public Health/Medical roles including Certified Nursing Assistants and Medical Assistants at 9%. Emergency Medical Personnel (EMT, Advanced EMT, Paramedic), comprised 7%.

FIGURE 6: *VOLUNTEER AGES*

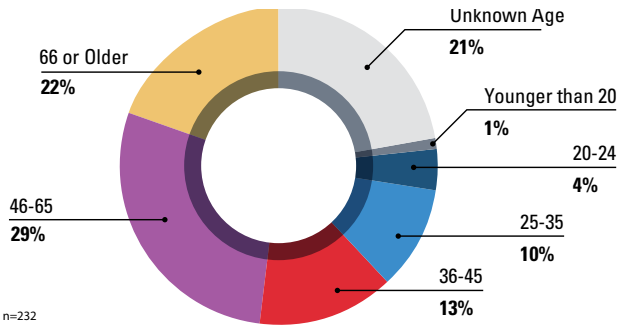
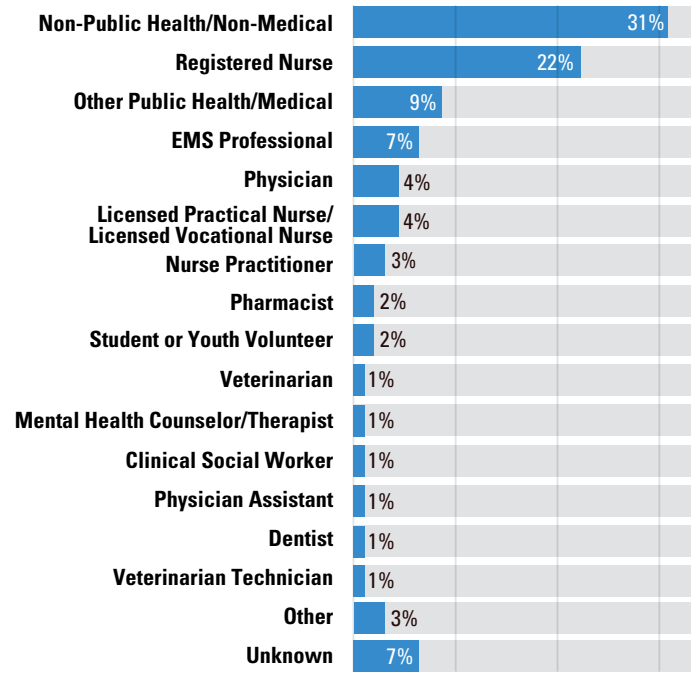


FIGURE 7: *VOLUNTEER DISCIPLINES*



New in 2024 were several roles not previously reported, including Mental Health Counselors, Clinical Social Workers, Physician Assistants, Dentists, and Veterinarian Technician, each comprising 1% of volunteers. Additionally, 7% of volunteers in 2024 were reported as unknown in terms of role.

In 2024, a total of 269,094 volunteer hours were reported among responding units. Of these, 29,802 hours were dedicated to emergency activities, with an average of 64 hours reported across 468 units. Non-emergency activities accounted for 239,292 hours, with an average of 520 hours reported across 460 units. FIGURE 8.

LEGAL PROTECTIONS

Legal protections for MRC volunteers vary across units. The following data helps unit leaders and stakeholders identify potential gaps.

Over half of units (51%) reported coverage by professional liability/ malpractice for volunteers during declared emergencies. About a third of units (37%) had professional liability coverage for public health activities and coverage for training activities (34%). FIGURE 9 (next page) highlights the circumstances in which volunteers were covered by their available legal protections (including federal, state, local, or departmental protections OR additional purchased coverage).

A majority (83%) of responding units have not purchased additional legal protection for their volunteers. More than three quarters of units (76%) do not offer training on legal protections for unit leaders or volunteers. Among those that do not offer training, a majority (61%) are interested in launching such training for unit leaders and 54% are interested in this training for volunteers.

KEY FINDINGS

In 2024, among responding units, 201,322 MRC volunteers provided 269,094 hours of service to communities across a range of geographies. These volunteers represent a variety of professional disciplines and ages. Similar to prior years' surveys, the opportunity to recruit younger volunteers remains, with 22% of volunteers aged 66 or older and just 5% aged 24 or younger.

FIGURE 8: *VOLUNTEER HOURS*

	Mean	Total Volunteer Hours
Emergency	64	29,802
Non-Emergency	520	239,292
All Volunteers		269,094

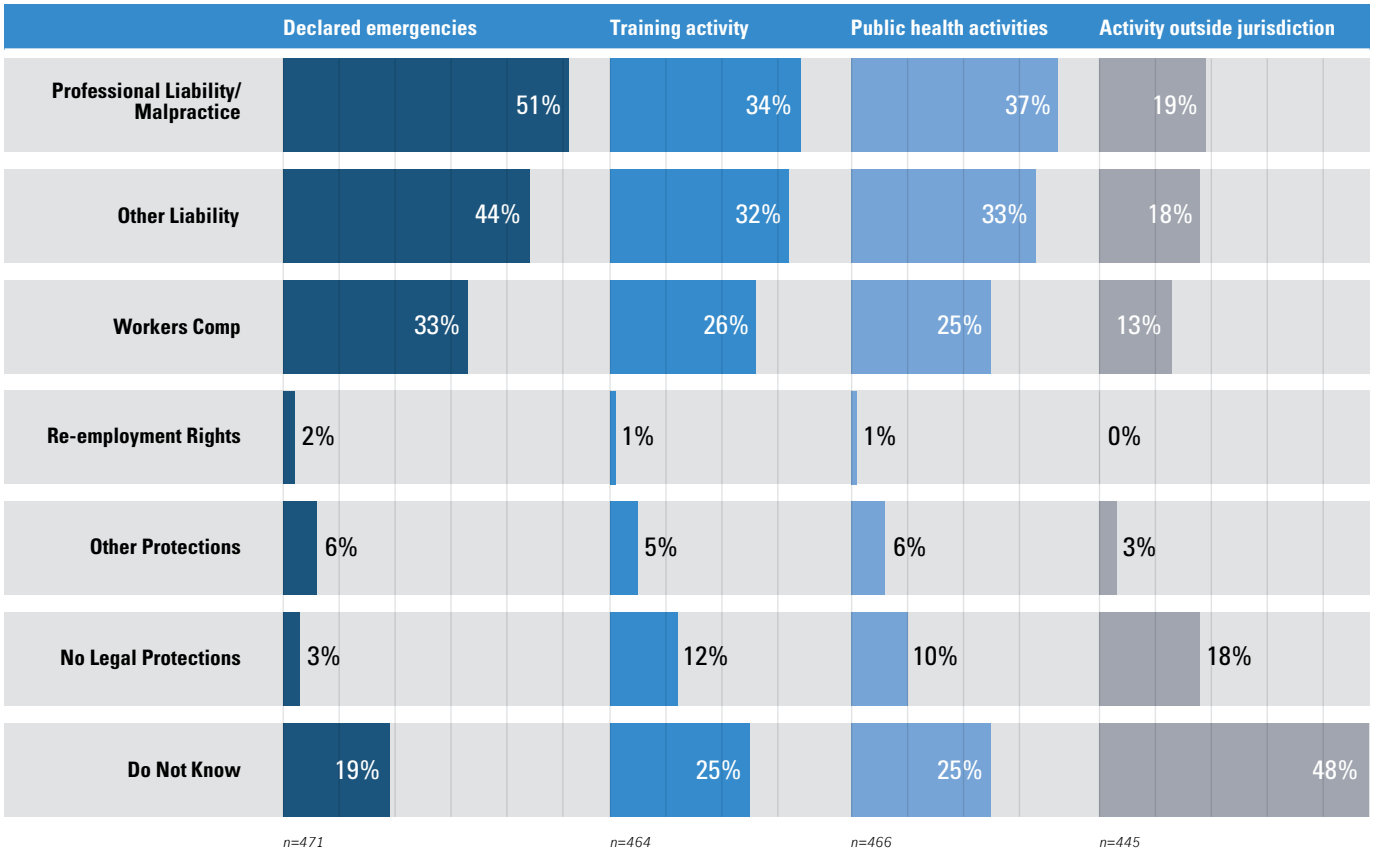
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Among unit leaders, 17% devote more than 35 hours a week to the MRC; while 47% devote less than 10 hours. The amount of time a unit leader has available to devote to MRC activities limits a unit's operational abilities, as seen through barriers noted in **Part Two: Volunteer Management** of this report. The length of time unit leaders have been in their position is fairly consistent with 2022's report with 16% of leaders serving in their position for less than one year and 39% of leaders serving for more than five years. These longevities illustrate the need to ensure training and resources are readily available for new leaders and that knowledge transfer and mentoring is fostered between newer and more experienced leaders. In 2024, over 600 MRC leaders participated in networking, special interest sessions, general sessions, and regional meetings at the 2024 MRC National Summit. In 2023, similar opportunities were available to 389 unit leaders and state coordinators through four regional workshops. In evaluations, over 90% of evaluation respondents agreed that they learned about new opportunities, including new partnerships, networking, sources for evidence base or funding sources. This speaks to the need for additional opportunities in the future.

As seen in prior reports, legal protections varied considerably by activity type and type of legal protection with over half (51%) providing professional liability/malpractice protection during declared emergencies. Among those that did not have trainings in place, a majority of unit leaders indicated an interest in trainings for both themselves and unit volunteers on legal protections. These findings illustrate a need for more resources and education around legal protections to ensure volunteers have the protection needed to support the public health workforce.

> "THE VOLUNTEERS ARE WELL TRAINED AND THERE FOR THE COMMUNITY."
>
> — ELLEN ARCHER, UNIT LEADER, EASTERN SHORE MRC, VIRGINIA

FIGURE 9: *LEGAL PROTECTIONS FOR VOLUNTEERS*



MRC Unit Snapshot

REFLECTING THE COMMUNITIES THEY SERVE

Medical Reserve Corps units are built on the support of leaders and volunteers at the community level to respond to community public health needs.

AVERAGE NUMBER OF VOLUNTEERS PER UNIT 430



TOTAL REPORTED: 201,322



UNIT LEADERS

COMMUNITIES SERVED BY MRC UNITS



35% SMALL
Serving Fewer than 100,000

22% MEDIUM
Serving 100,000-250,000

44% LARGE
Serving more than 250,000



84%
hold paid positions



61%
have less than five years of Experience in their role as MRC Unit Leader

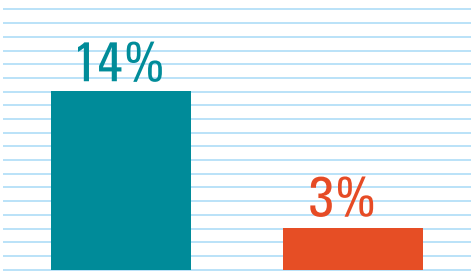


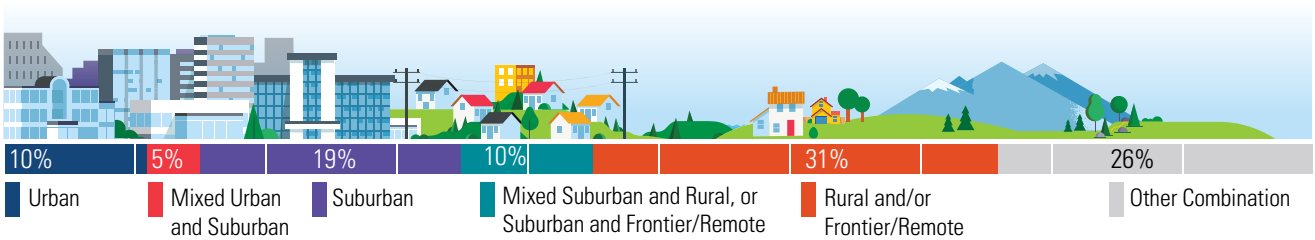
39%
Have served five years or more in their role as an MRC unit Leader

UNIT DEMOGRAPHICS



68%
of MRCs are affiliated with their local health department (an increase compared to 64% in 2020)





PART 2

VOLUNTEER MANAGEMENT

Effectively managing Medical Reserve Corps volunteers is essential to ensuring units are prepared to support both routine public health activities and emergency responses. From recruiting and onboarding new members to providing ongoing training and evaluation, the way a unit engages its volunteers directly influences their readiness and dependability. When volunteers are properly screened, trained in relevant areas, and actively involved, they become a reliable extension of the public health workforce.

VOLUNTEER RECRUITMENT, SCREENING, AND CREDENTIAL VERIFICATION

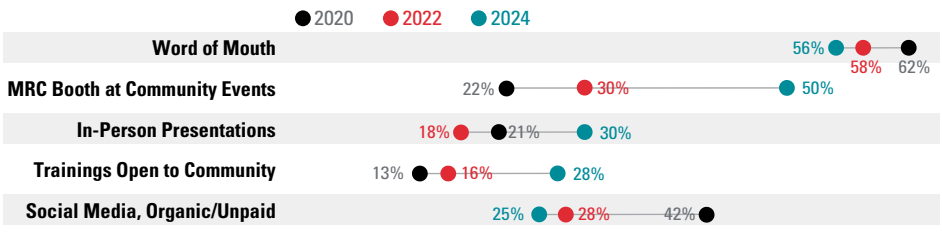
RECRUITMENT METHODS

MRC units across the country continue to engage in a variety of strategies to recruit new volunteers. In 2024, MRC units used a mix of traditional and in-person methods to attract individuals interested in supporting public health preparedness and response. FIGURE 10.

A majority of respondents (56%) reported word of mouth among the top three recruitment methods. This was followed by recruiting through an MRC booth at community events (50%) and in-person presentations (30%).

Other methods, such as trainings open to the community and organic/unpaid social media, were less commonly reported, selected by 28% and 25% of units, respectively. Traditional paid advertising methods, such as newspaper/online ads, social media, radio ads, television ads, and volunteer websites were among the least used recruitment strategies.

FIGURE 10: *TOP RECRUITMENT METHODS*



n=461-504

KEY HIGHLIGHTS

77% OF UNITS HAVE A WRITTEN TRAINING PLAN.

56% OF MRC UNITS REPORTED WORD OF MOUTH AS THE MOST EFFECTIVE FORM OF RECRUITMENT.



WEST TEXAS MRC, TEXAS

FIGURE 11: *RECRUITMENT BARRIERS*

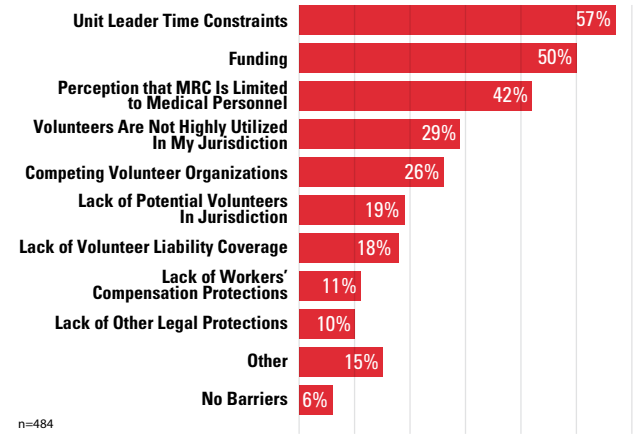


FIGURE 12: *BACKGROUND CHECKS ON VOLUNTEERS*

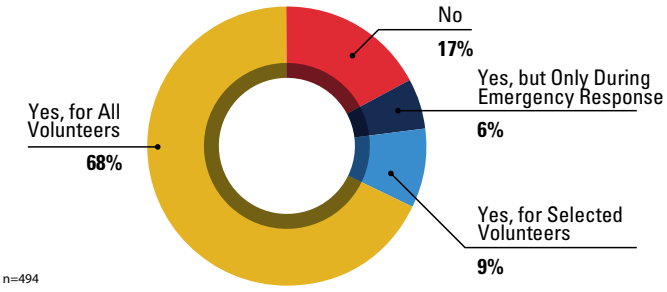


FIGURE 13: *HOW TRAINING PLANS WERE DEVELOPED*

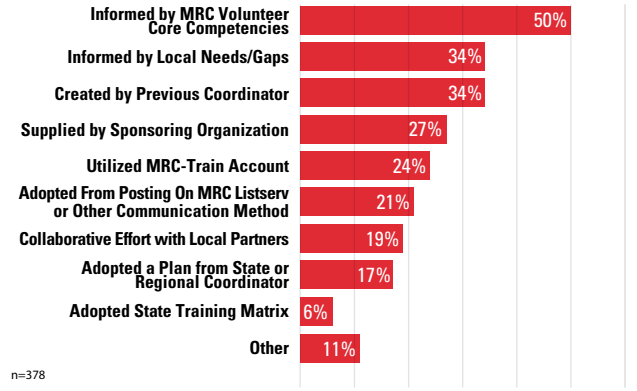
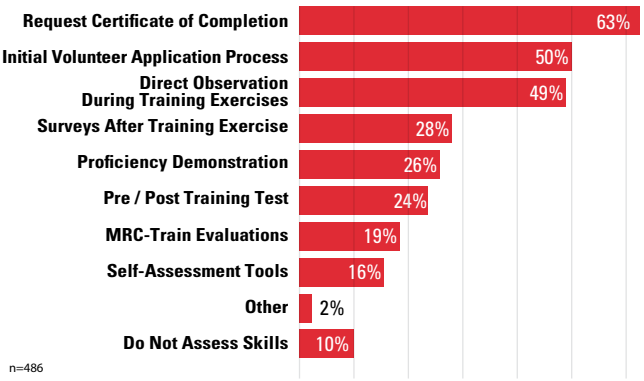


FIGURE 14: *ASSESSING VOLUNTEER SKILLS*



BARRIERS TO VOLUNTEER RECRUITMENT

In 2024, the most frequently reported barrier to volunteer recruitment was unit leader time constraints (57%); funding constraints followed at 50%. Misconceptions that the MRC is only for medical professionals were noted by 42% of responding units, while 29% cited challenges with underutilizing volunteers. Legal concerns were less common, with 18% mentioning lack of volunteer liability coverage, 11% citing lack of workers' protections compensation, and 10% referencing lack of protections. Competition from other volunteer organizations was reported by 26%, and 19% noted a limited pool of potential volunteers. Only 6% of units indicated no barriers. FIGURE 11.

BACKGROUND SCREENING AND VERIFICATION OF MEDICAL CREDENTIALS

In 2024, over two in three responding MRC units (68%) conducted background checks on all volunteers, while under one in 10 (9%) did so only for selected volunteers, and 6% did so only during emergency response. Almost four in five MRC units (79%) reported verifying volunteers' medical credentials through a state registry or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system. FIGURE 12.

VOLUNTEER TRAINING PLANS AND CORE COMPETENCIES

Training is a foundational element of MRC operations, ensuring volunteers are prepared to respond effectively during public health emergencies. Many units base their approach on the MRC Core Competencies, adapted from the framework developed by the National Center for Disaster Medicine and Public Health (NCDMPH). These competencies cover four key areas: Volunteer Preparedness, Volunteer Response, Volunteer Leadership, and Volunteer Support for Community Resiliency.

Over three in four responding MRC units (77%) reported having a written volunteer training plan in place. This marks an improvement from 2022, when the rate dipped to 70%, and aligns with historical patterns observed between 2017 and 2020, which ranged from 73% to 78%.

When asked how their volunteer training plans were developed, half of responding units (50%) indicated that plans were informed by the MRC Core Competencies. Other common sources included being created by previous coordinators (34%), being informed by local needs or gaps assessments (34%), part or all being supplied by the sponsoring organization (27%), and by utilizing the MRC-TRAIN platform (24%). A small percentage of responding units (6%) adopted the state training matrix. FIGURE 13.

Most responding MRC units assess volunteer skills through formal documentation and structured processes. FIGURE 14. The most common methods reported included requesting certificates of completion (63%), using the initial volunteer application process (50%), and direct observation during training exercises (49%). Less frequently used approaches include self-assessment tools (16%) and MRC-TRAIN evaluations (19%).

In 2024, when asked if MRC volunteer Core Competencies were used overall by MRC units; 62% of units reported using MRC volunteer Core Competencies, 17% did not, and 21% were unsure.

Respondents were asked about their awareness and use of key

deployment readiness resources. FIGURE 15. Awareness levels were relatively high, ranging from 58% to 65% across tools, but actual usage was significantly lower. For example, while 65% were aware of the MRC Unit Leader Deployment Readiness Checklists, only 33% had used them. Similarly, 63% were aware of mission sets, but only 30% reported using them.

Despite general awareness of the Deployment Readiness Guide resources, many respondents indicated they were unable to implement them. Among those who were aware of this resource, the most common barrier to use was limited staff time.

VOLUNTEER TRAINING

Analysis of 2024 data shows that MRC units continue to offer a wide range of trainings to support volunteer readiness. The most common mandatory trainings included MRC 101/Unit Orientation (48%), Introduction to the Incident Command System (ICS-100) (43%), National Incident Management System (ICS-700) (37%), Health Insurance Portability and Accountability Act (HIPAA) (33%), and Incident Command System Single Resources (IS-200) (23%).

The most widely available online courses were Introduction to the ICS-100 (79%), ICS-700 (78%), IS-200 (78%), and IS-800 (75%). Personal and Family Preparedness was offered online by 53% of responding units, while Bloodborne Pathogens' was offered online by 47% in 2024.FIGURE 16. This indicates a growth from 17% in 2022, not shown in figure.

Clear, reliable communication remains critical for MRC units to manage operations, support volunteers, and engage external partners. Communication patterns in 2024 aligned closely with those reported in the *2022 Network Profile of the MRC*, with email remaining the primary communication tool. FIGURE 17 (next page). It was used by 93% of responding units for non-emergency communication and by 65% of units for emergency response/

FIGURE 15: *DEPLOYMENT READINESS GUIDE USAGE*

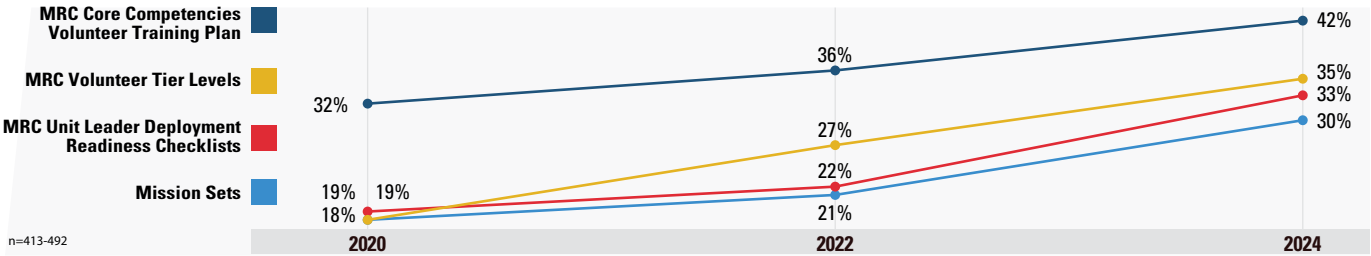
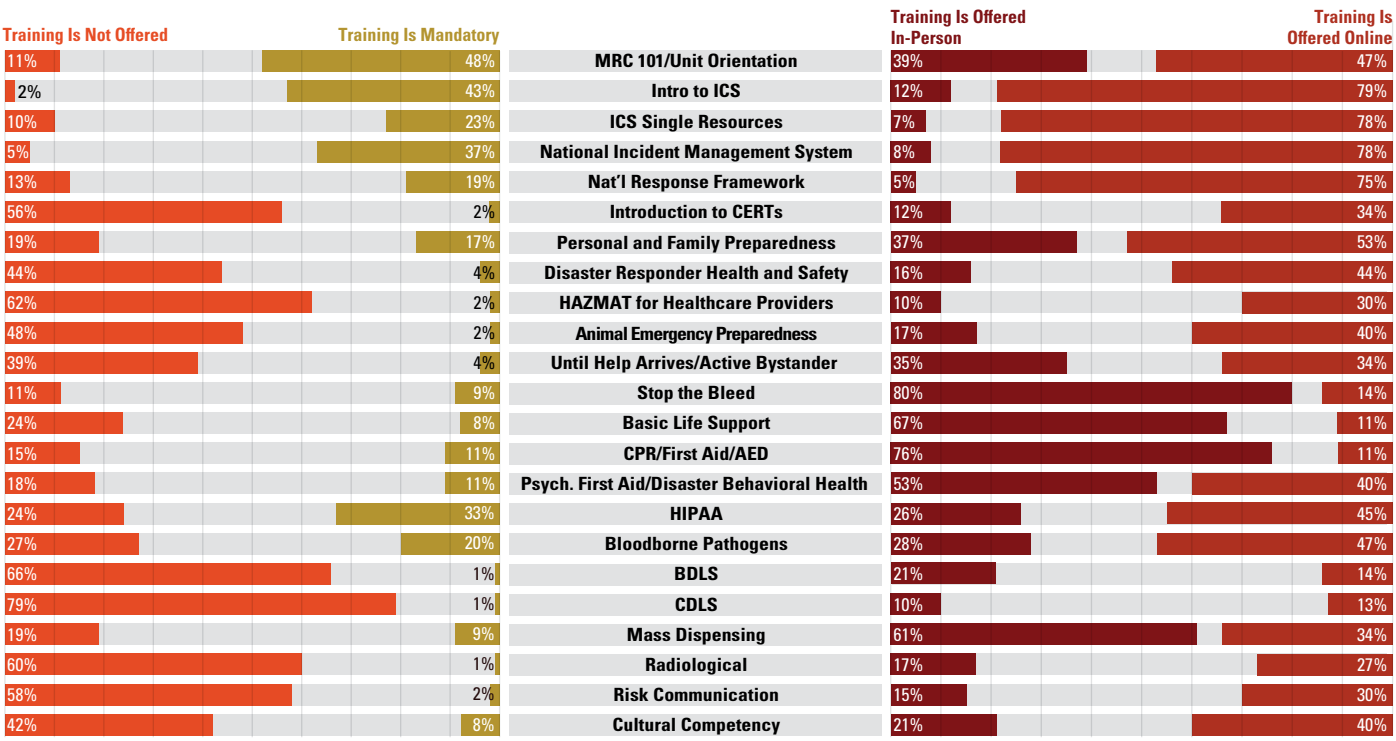


FIGURE 16: *TRAININGS OFFERED BY MRC UNIT*



n=356-470

activation communications. Video conferencing platforms such as Zoom, Microsoft Teams, and Google Meet were frequently used for routine operations, with 70% of units reporting their use for non-emergency communication. However, usage dropped to 33% during emergency responses.

While general email was the most prevalent channel, specific systems like ESAR-VHP or state-based platforms were strongly preferred for both non-emergency (71%) and emergency (72%) communication. Text messaging and automated phone systems through ESAR-VHP or state systems were less utilized for non-emergencies (40% and 25%, respectively), but usage increased during emergencies to 56% and 50%, respectively.

When sharing good news about their unit or advocating for support, at least 70% of responding MRCs use email to communicate with sponsoring agency leadership or local health departments. More than 60% also use newsletters to communicate with these partners. More than 60% use presentations to share good news or advocate for support with local health departments and community partners. For government officials, this type of communications is more commonly shared via email than other forms (41%), while press releases are the most common communications channel used with local media partners.

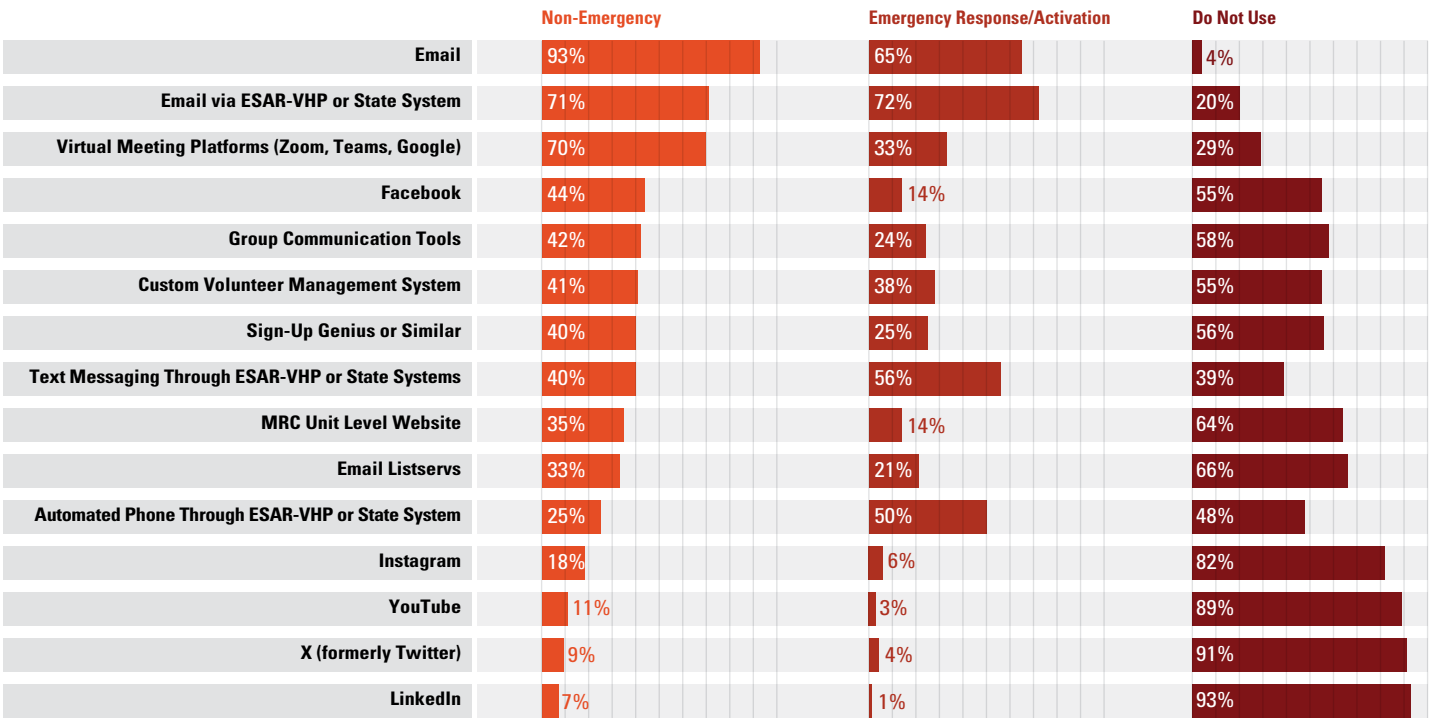
KEY FINDINGS

Effective volunteer management remains central to the success of MRC units. In 2024, units continued to invest in recruitment, training, and communication strategies that reflect both local needs and national standards. Most units relied on local relationships and in-person engagement to build their volunteer base, with word-of-mouth (56%) and booths at community events (50%) being the most effective strategies reported among respondents. Digital outreach remained limited. Time constraints and funding were the most common barriers, reflecting broader capacity challenges.

Training practices have remained a core strength across the network. A majority of responding units (77%) reported having written training plans. Half of the units developed their plans using MRC Core Competencies. Despite moderate awareness of Deployment Readiness Tools (58–65%), actual usage was low (30–33%), mainly due to limited staff time.

Online training for volunteers remained the most widely used delivery method across the MRC network, with core emergency management courses such as ICS-100, ICS-700, and CPR/First Aid consistently available. In-person training continued to support hands-on skill development, with notable growth in offerings like Stop the Bleed, Mass Dispensing, and Psychological First Aid. Advanced training courses remain less common.

FIGURE 17: *CHANNELS USED TO COMMUNICATE WITH VOLUNTEERS*



n=393-475

MRC Volunteer Management

BUILDING A TRAINED AND READY VOLUNTEER WORKFORCE

Effective volunteer management remains central to the success of MRC units. In 2024, units continued to invest in recruitment, training, and communication strategies that reflect both local needs and national standards.

TRAINING

77% of units have a written volunteer training plan

50% of MRC units use the MRC Volunteer Core Competencies to inform their volunteer training plans

63% of units request certificate of completion to assess volunteer skills

RECRUITMENT

58% of MRC indicated word-of-mouth as the most effective form of recruitment



VERIFICATION

68% of MRC units conducted background checks for their volunteers

79% of MRC units used the state registry or ESAR-VHP system to verify volunteers' medical credentials

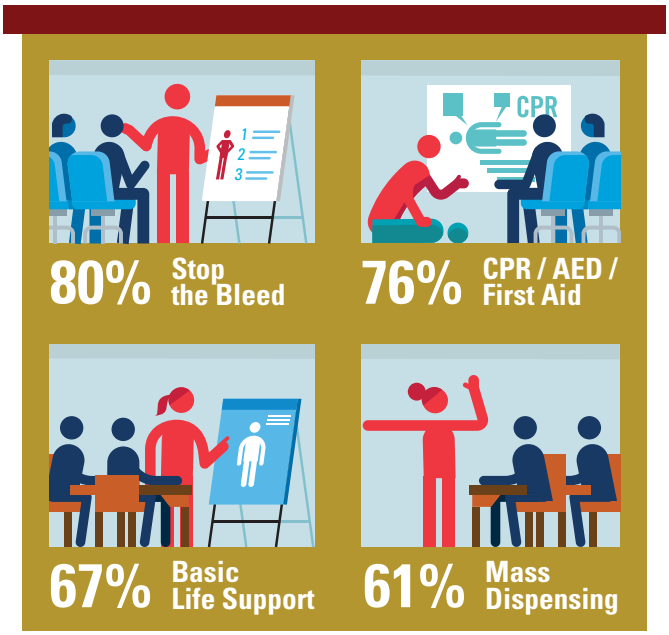
RECRUITMENT BARRIERS



57% of MRC units report unit leader time constraints as the largest barrier to recruitment

50% of MRC units report lack of funding as the second largest barrier to recruitment

TOP IN THE FIELD OR IN-PERSON TRAININGS OFFERED





LAKE COUNTY MRC, OHIO

UNIT CAPABILITIES AND RESPONSIVENESS

When speaking about MRC units, capabilities are defined as the skills, resources, and abilities they possess to support their communities during emergencies and to strengthen public health initiatives. The findings from the 2024 MRC Network Profile survey provide a picture of emergency and non-emergency capabilities of the MRC.

CAPABILITIES AND MISSION SETS SUSTAINED OR DEVELOPED

Mission sets are planning tools that allow units to compile basic information using a standard template for response activities that can be shared with stakeholders. MRC units develop mission sets to support medical and public health emergencies such as Points of Dispensing (PODs), shelter operations, medical surge support, disaster behavioral health, family assistance centers, and mass casualty support.

Overall in 2024, the top three mission sets developed were medical point of distribution/mass vaccination, general shelter support, and vaccine clinic/drive-thru clinics; 45%, 34%, and 32% of responding units reported these, respectively. Notably, 33% of responding units indicated not developing any mission sets. FIGURE 18 (next page).

CAPABILITIES DEPLOYED

FIGURE 19 (next page) displays the capabilities deployed in 2024. Among survey respondents, units were most often deployed for community education trainings (43%), conducting personal and family preparedness information campaigns (34%), and health clinic support (35%).

Capabilities that the fewest number of units reported developing or deploying were search and rescue support, family assistance center, and disaster resilience.

TYPES OF ORGANIZATIONAL SUPPORT

MRC units receive support from a number of different sources to help them operate efficiently. FIGURE 20 (page 23). Among respondents, a unit's sponsoring organization was most likely to provide materials (72%), leadership (72%), and staff assistance (70%). State agencies (i.e., state health department, state emergency management agency) provided training (67%) and materials (50%); federal agencies provided training (50%) and funding (43%).

Strong partnerships are essential to the success and sustainability of MRC units. FIGURE 21 (page 23). In 2024, the most commonly reported response unit partners included local emergency management agencies (77%), local health departments (76%), and healthcare coalitions (59%).

KEY HIGHLIGHTS

62% OF MRC UNITS REPORTED WORKING WITH OTHER MRC UNITS ON JOINT TRAININGS AND EXERCISES.

MRC VOLUNTEERS DEPLOYED TO SUPPORT COMMUNITY EDUCATION, HEALTH CLINIC SUPPORT, AND PERSONAL AND FAMILY PREPAREDNESS CAMPAIGNS.

Among respondents, joint training and exercise activities were most frequently conducted with local emergency management (57%), other MRC units (54%), and healthcare coalitions (41%), highlighting a focus on collaborative preparedness.

Despite these strengths, partnerships remain limited with a few organizations. Notably, many units reported no partnerships with faith-based organizations, pharmacies, long-term care facilities, and animal care.

MRC UNITS WORKING TOGETHER

In 2024, MRC units worked together to support preparedness and response activities. Overall, 68% of respondents reported working with other MRC units for state and regional meetings and 62% in joint trainings and exercises. Few (11%) reported not working with other MRC units. **FIGURE 22** (next page).

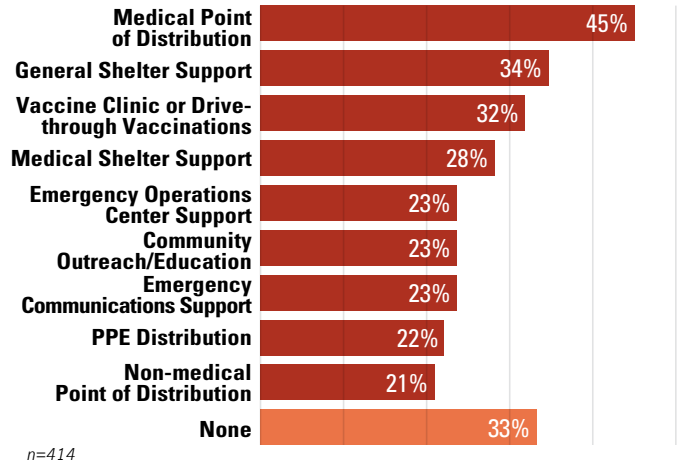
KEY FINDINGS

Blue skies refer to the non-disaster periods when preparedness planners and managers focus on proactive measures like planning, training, and community outreach. Since the end of the pandemic, MRC units have been focused on sustaining existing traditional capabilities including support for community trainings, personal preparedness, and public health clinic support. Forty-two percent of units reported having mental and behavioral health capabilities—with 17% newly developing these in 2024—which, considering reports of behavioral health shortages across the country, is valuable.

A majority of units worked with local emergency management agencies, local health departments, or healthcare coalitions as response partners in 2024. These relationships reflect the critical role MRC units play in coordinated public health and emergency response efforts. Partnerships remain limited with some other types of organizations and indicate potential areas of growth and development.

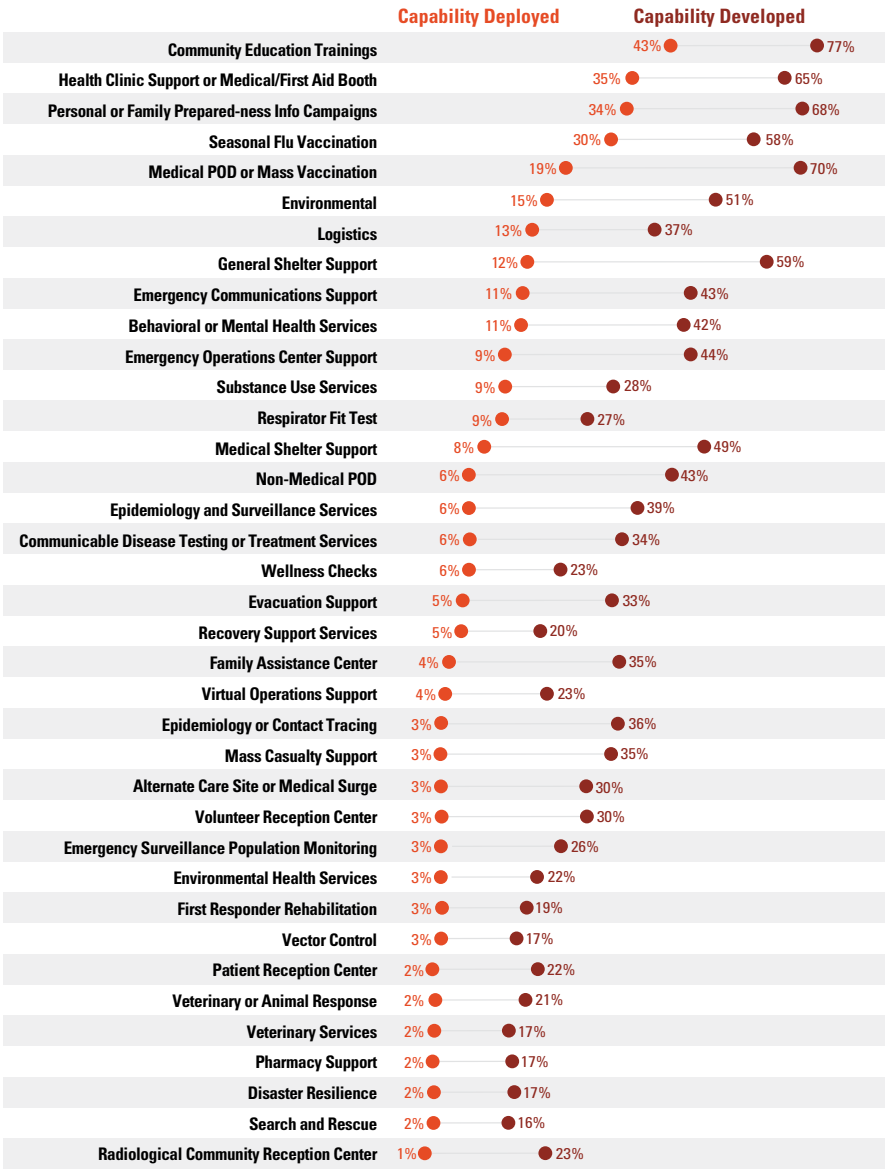
In 2024, a formal national partnership between the Office of the Medical Reserve Corps and the American Red Cross focusing on community preparedness, response, and recovery from disasters and public health emergencies was finalized. This Memorandum of Agreement (MOA), provides a framework for collaboration at both national and local levels to enhance community resilience. As this report indicates, in 2024, 21% of units reported having a written agreement and 34% reported having joint exercises or trainings with the American Red Cross. This MOA may be helpful in the future for MRC units to strengthen formal collaborations.

FIGURE 18: *TOP MISSION SETS*



n=414

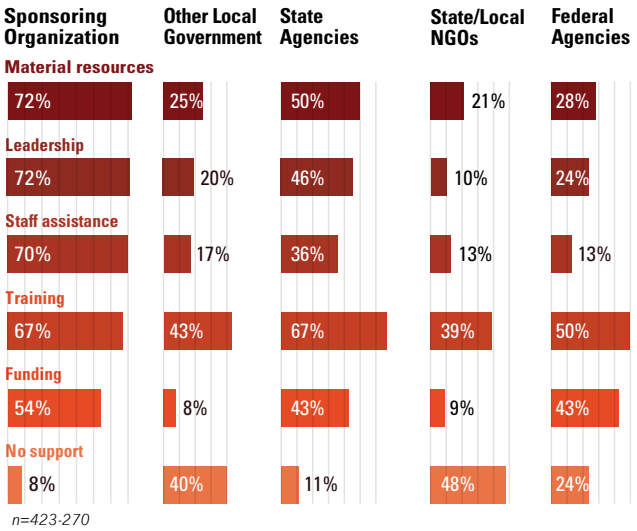
FIGURE 19: *MRC UNIT CAPABILITIES*



n=453

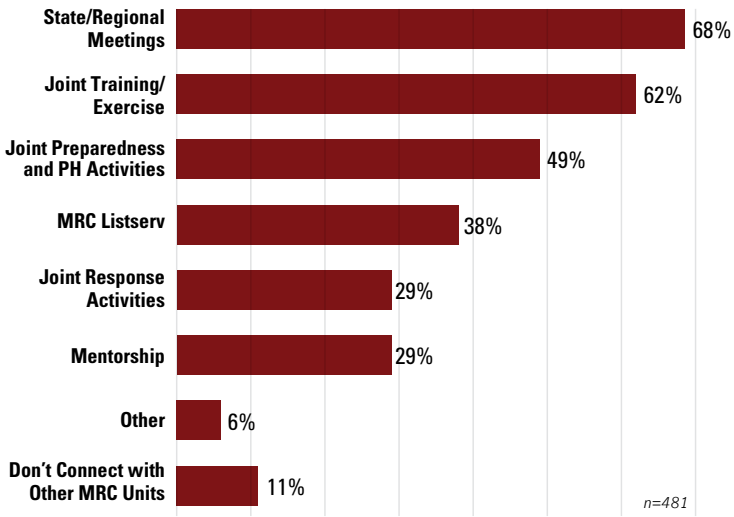
Note: "Developed" includes MRC units reporting the capability was developed prior to calendar year 2024 OR newly developed/updated in calendar year 2024.

FIGURE 20: *SUPPORT FROM AGENCIES/ORGANIZATIONS*



n=423-270

FIGURE 22: *UNITS WORKING WITH ANOTHER MRC UNIT*

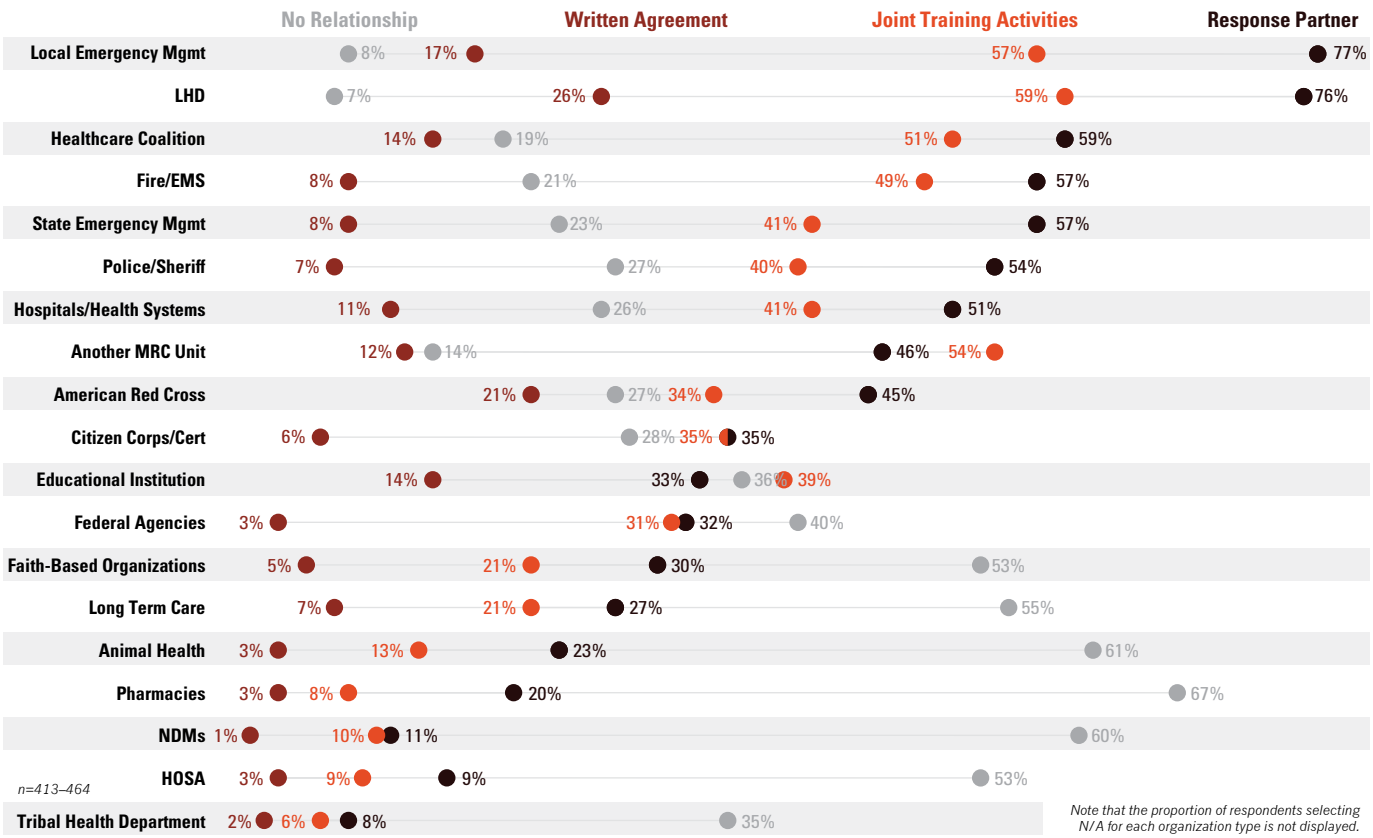


n=481

"IT'S INSPIRING. THESE VOLUNTEERS WANT TO GIVE BACK."

— TIFFANY SINGER, UNIT LEADER, PICKAWAY COUNTY MRC, OHIO

FIGURE 21: *MRC UNIT PARTNERSHIPS*



n=413–464

Note that the proportion of respondents selecting N/A for each organization type is not displayed.



UPPER MERRIMACK VALLEY MRC, MASSACHUSETTS

MRC Unit Capabilities

BUILDING CAPACITY TO DEPLOY AND RESPOND IN COMMUNITIES

Proactive activities to plan and train for emergencies and community preparedness activities ensure that MRC volunteers can deploy locally as a trained and ready surge capacity public health workforce.

UNIT CAPABILITIES DEPLOYED

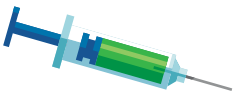


43% Community Education Trainings

35% Health Clinic Support

34% Personal/Family Preparedness Information Campaigns

TOP 3 MISSION SETS DEVELOPED



45% Medical POD or Mass Vaccination

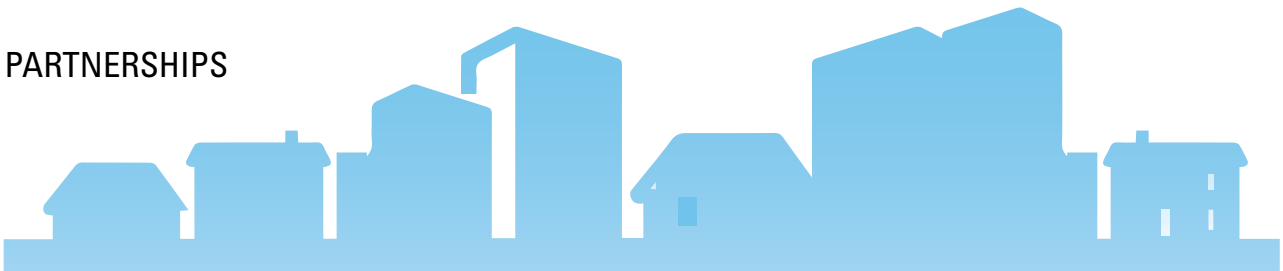


32% General Shelter Support



34% Clinic / Drive-Through Testing / Vaccinations

PARTNERSHIPS



MRC UNIT PARTNERS

Reported working with other MRC units for state and regional meetings **68%**

Reported working in joint trainings and exercises **62%**

RESPONSE PARTNERS

Local Emergency management **77%**

Local Health Departments **76%**

Healthcare Coalitions **59%**

OTHER UNIT PARTNERS

Reported having a written agreement with the American Red Cross **21%**

Reported conducting joint exercises and training **34%**



SHELBY COUNTY MRC, TENNESSEE

FUTURE DIRECTIONS

Medical Reserve Corps units are vital components of community-based public health preparedness, enhancing self-reliance by providing a trained and organized volunteer force to respond to emergencies. For more than 20 years, this network of volunteers organized locally has responded to community health and safety needs during emergencies and built community resiliency through preparedness, prevention, and public health activities.

Information provided in this profile report shows that in 2024 at least 269,094 hours of service were provided by trained volunteers across a range of activities. These included emergency activities like support of medical shelters and Emergency Operations Centers as well as non-emergency activities like support of health clinics and behavioral/mental health services. NACCHO makes the following recommendations to inform future MRC network activities.

BUILD MRC UNIT CAPABILITIES

NACCHO recommends sustaining the capabilities of local, state, and federal stakeholders to respond to the unique risks of communities through strong volunteer management, including support for MRC units in local communities. As noted in the report's **Part 3: Unit Capabilities and Responsiveness**, effectively managing MRC volunteers is essential to ensuring units are prepared to support emergency response and bolster community preparedness and resilience. Among survey respondents, units most often deployed for community education trainings (43%), conducting personal and family preparedness information campaigns (34%), and health clinic support (35%). These efforts are vital to fostering individual preparedness and building community resilience.

MAINTAIN UNIT CAPACITY TO DEPLOY BY SUSTAINING VOLUNTEER COMPETENCY

To effectively deploy, volunteers must be trained to respond to the needs of their communities. More than three-quarters (77%) of responding MRC units indicated they have a written volunteer training plan and 62% of units reported incorporating the MRC Core Competencies into their training plans. Continued investment in training activities is critical to unit success. NACCHO recommends that units continue to train based on developed core

KEY HIGHLIGHTS



IN 2024, VOLUNTEERS PROVIDED AT LEAST 269,094 HOURS OF SERVICE.



VOLUNTEERS MUST BE TRAINED TO RESPOND TO THE NEEDS OF THEIR COMMUNITIES.

competency sets and that units be provided the resources to train to those standards. This could be through maintenance of existing training platforms or provision of direct peer-to-peer training.

To maintain unit capacity, MRC unit leaders require dedicated time to support unit operations. As noted in **Part 1: MRC Demographics and Composition** in this report, 47% devote less than 10 hours; just 17% of unit leaders devote 35 or more hours a week to the MRC. The limited amount of time staff have available to devote to managing their MRC unit limits the unit's abilities and can impact their response capabilities. The most frequently reported barrier to volunteer recruitment was limited time among unit leaders (57%). This presents challenges to ensuring a unit has the number of volunteers required to meet response needs. In terms of resource use, the most common barrier was limited staff time among those who reported they were aware of the resources in the Deployment Readiness Guide, a comprehensive guide aimed at increasing MRC units' deployment readiness.

Data also points to the need to retain and foster professional development among unit leaders. Among respondents, 16% have held their position for less than a year and 45% less than five years. This highlights a need to ensure that training and resources are readily available and accessible to leaders who are new in their role. As 39% of respondents reported 10 or more years in their role, this also presents opportunities for knowledge sharing and mentorship with newer unit leaders.

For example, in 2023 and 2024, NACCHO, under its cooperative agreement with ASPR, hosted four regional workshops and one national conference for MRC unit leaders and state coordinators. Evaluation results demonstrated that 97% of responding leaders indicated the information provided will be useful to their professional/volunteer work or practice and 97% indicated they will use the knowledge gained during the conference to improve their work. Furthermore, 93% of respondents agreed that they learned about new opportunities, including new partnerships, networking, sources for evidence base, or funding sources. NACCHO recommends that similar national and regional convenings would be useful to sustain unit leader and volunteer competency.

> "OUR VOLUNTEERS ARE SELFLESS. THEY'RE DEPENDABLE AND WILLING TO PITCH IN."
>
> — LUWANA MILNER, UNIT COORDINATOR, LAKE COUNTY MRC, FLORIDA

FOSTER PARTNERSHIPS AND INTERSTATE COLLABORATION

NACCHO recommends collaboration by stakeholders to better understand the complexities of interstate and intrastate volunteer deployment to respond to emergencies and build community resilience. This includes the ability to support responses that cross city, county, and state borders and the utilization of the Emergency Management Assistance Compact (EMAC). As noted in **Part Three: Unit Capabilities and Responsiveness** in this report, strong partnerships are essential to the success and sustainability of MRC units. In 2024, the most commonly reported unit response partners included local emergency management agencies (77%), local health departments (76%), and healthcare coalitions (59%). Notably, units reported low levels of formal agreements and joint training activities with faith-based organizations, pharmacies, long-term care facilities, and animal care.

In 2024, the Office of Medical Reserve Corps and the American Red Cross finalized an updated Memorandum of Agreement. The MOA serves to define a working relationship and set forth principles under which the national offices of the American Red Cross and the OMRC will work to promote and enhance cooperation between the two organizations. The agreement describes potential areas of collaboration (e.g., preparedness and response activities) and aims to provide a broad framework for partnership implementation at the regional and local levels. Leadership at the federal level is critical to the development of these types of partnerships. Technical assistance to MRC units in developing such partnerships at the local level is needed to ensure communities are able to implement them.

Data provided in this report demonstrates that, in blue skies, MRC units are maintaining their capacity, promoting individual resiliency, and supporting outbreaks in their communities. A coordinating national entity is needed to ensure response capabilities are deployable across state lines. MRC state coordinators may also be a resource in such efforts. NACCHO recommends maintenance of national coordination efforts to ensure efficient deployment of MRC assets when needed.

CASE STUDY

MRC Volunteers Support Behavioral Health Needs in Communities

VOLUNTEERS DEPLOY IN SUPPORT OF AN ARRAY OF EMERGENCIES.

The Minnesota Behavioral Health Medical Reserve Corps is a statewide unit housed under the state department of health. Its 37 active volunteers all have a connection to behavioral health.

Volunteers include psychologists, therapists, social workers, pharmacists, nurses, EMTs, school nurses, and chaplains. These are volunteers who are aware of the behavioral health services in Minnesota.

The unit's volunteers have supported deployments including floods, fires, wildfires, and bird flu. Volunteers generally work in four-person teams with a team leader and clinical lead.

One such deployment was to a flooded area in northern Minnesota. This was a multi-agency response involving the U.S. Department of Homeland Security, including its Federal Emergency Management Agency (FEMA), as well as the U.S. Small Business Administration. Unit volunteers provided behavioral health support, going with the team into communities.

"They heard a lot of stories of those battling the flooding night and day for two months," said Unit Coordinator Janet Yeats. "Volunteers listened to homeowners and business owners who just needed to tell their story. We provided a listening ear and checked in on them."

Volunteers worked not just with the survivors but with those on the team supporting the community.

"They got impacted—we heard their stories, too," said Yeats.

To prepare its volunteers to deploy, the unit has a set number of required trainings which include introduction to NIMS and ICS, and Psychological First Aid. Recommended trainings include Skills for Psychological Recovery, De-escalation, Grief and Loss, and Managing Trauma.

2024 MRC NATIONAL SUMMIT, CHICAGO, ILLINOIS





MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH MEDICAL RESERVE CORPS, ARIZONA

“MRC VOLUNTEERS HAVING THAT LOCAL CONNECTION TO THE COMMUNITY IS SO VALUABLE.”

— BRIDGET VELASCO, UNIT COORDINATOR, MAUI COUNTY HEALTH VOLUNTEERS, HAWAII

APPENDIX A

This appendix provides accessible data tables corresponding to figures and infographics throughout the report that contain complex or detailed information that cannot be adequately conveyed through alternative text alone. The tables are intended to provide an equivalent means of accessing the underlying data, relationships, and information presented in these visualizations. Each table is identified by the corresponding figure number to help readers easily locate the accessible information associated with a specific figure.

FIGURE 7: *VOLUNTEER DISCIPLINES*

Non-Public Health/Non-Medical	31%
Registered Nurse	22%
Other Public Health/Medical	9%
EMS Professional	7%
Physician	4%
Licensed Practical Nurse/Licensed Vocational Nurse	4%
Nurse Practitioner	3%
Pharmacist	2%
Student or Youth Volunteer	2%
Veterinarian	1%
Mental Health Counselor/Therapist	1%
Clinical Social Worker	1%
Physician Assistant	1%
Dentist	1%
Veterinarian Technician	1%
Other	3%
Unknown	7%

n=356

FIGURE 9: *LEGAL PROTECTIONS FOR VOLUNTEERS*

	Declared emergencies	Training activity	Public health activities	Activity outside jurisdiction
Professional Liability/ Malpractice	51%	34%	37%	19%
Other Liability	44%	32%	33%	18%
Workers Comp	33%	26%	25%	13%
Re-employment Rights	2%	1%	1%	0%
Other Protections	6%	5%	6%	3%
No Legal Protections	3%	12%	10%	18%
Do Not Know	19%	25%	25%	48%
	n=471	n=464	n=466	n=445

FIGURE 16: *TRAININGS OFFERED BY MRC UNIT*

	Training Is Not Offered	Training Is Mandatory	Training Is Offered In-Person	Training Is Offered Online
MRC 101/Unit Orientation	11%	48%	39%	47%
Intro to ICS	2%	43%	12%	79%
ICS Single Resources	10%	23%	7%	78%
National Incident Management System	5%	37%	8%	78%
National Response Framework	13%	19%	5%	75%
Introduction to CERTs	56%	2%	12%	34%
Personal and Family Preparedness	19%	17%	37%	53%
Disaster Responder Health and Safety	44%	4%	16%	44%
HAZMAT for Healthcare Providers	62%	2%	10%	30%
Animal Emergency Preparedness	48%	2%	17%	40%
Until Help Arrives/Active Bystander	39%	4%	35%	34%
Stop the Bleed	11%	9%	80%	14%
Basic Life Support	24%	8%	67%	11%
CPR / First Aid / AED	15%	11%	76%	11%
Psychological First Aid or Disaster Behavioral Health	18%	11%	53%	40%
HIPAA	24%	33%	26%	45%
Bloodborne Pathogens	27%	20%	28%	47%
BDLS	66%	1%	21%	14%
CDLS	79%	1%	10%	13%
Mass Dispensing	19%	9%	61%	34%
Radiological	60%	1%	17%	27%
Risk Communication	58%	2%	15%	30%
Cultural Competency	42%	8%	21%	40%

n=356-470

FIGURE 17: *CHANNELS USED TO COMMUNICATE WITH VOLUNTEERS*

	Non-Emergency	Emergency Response/Activation	Do Not Use
Email	93%	65%	4%
Email via ESAR-VHP or State System	71%	72%	20%
Virtual Meeting Platforms (Zoom, Teams, Google)	70%	33%	29%
Facebook	44%	14%	55%
Group Communication Tools	42%	24%	58%
Custom Volunteer Management System	41%	38%	55%
Sign-Up Genius or Similar	40%	25%	56%
Text Messaging Through ESAR-VH P or State Systems	40%	56%	39%
MRC Unit Level Website	35%	14%	64%
Email Listservs	33%	21%	66%
Automated Phone Through ESAR-VHP or State System	25%	50%	48%
Instagram	18%	6%	82%
YouTube	11%	3%	89%
X (formerly Twitter)	9%	4%	91%
LinkedIn	7%	1%	93%

n=393-475

FIGURE 18: *TOP MISSION SETS*

Medical Point of Distribution	45%
General Shelter Support	34%
Vaccine Clinic or Drive-through Vaccinations	32%
Medical Shelter Support	28%
Emergency Operations Center Support	23%
Community Outreach/Education	23%
Emergency Communications Support	23%
PPE Distribution	22%
Non-medical Point of Distribution	21%
None, my unit has not developed any Mission Set Planning Documents	33%

n=414

FIGURE 19: *MRC UNIT CAPABILITIES*

Type of Capability	Capability Deployed	Capability Developed
Community Education Trainings	43%	77%
Health Clinic Support or Medical/First Aid Booth	35%	65%
Personal or Family Prepared-ness Info Campaigns	34%	68%
Seasonal Flu Vaccination	30%	58%
Medical POD or Mass Vaccination	19%	70%
Environmental	15%	51%
Logistics	13%	37%
General Shelter Support	12%	59%
Emergency Communications Support	11%	43%
Behavioral or Mental Health Services	11%	42%
Emergency Operations Center Support	9%	44%
Substance Use Services	9%	28%
Respirator Fit Test	9%	27%
Medical Shelter Support	8%	49%
Non-Medical POD	6%	43%
Epidemiology and Surveillance Services	6%	39%
Communicable Disease Testing or Treatment Services	6%	34%
Wellness Checks	6%	23%
Evacuation Support	5%	33%
Recovery Support Services	5%	20%
Family Assistance Center	4%	35%
Virtual Operations Support	4%	23%
Epidemiology or Contact Tracing	3%	36%
Mass Casualty Support	3%	35%
Alternate Care Site or Medical Surge	3%	30%
Volunteer Reception Center	3%	30%
Emergency Surveillance Population Monitoring	3%	26%
Environmental Health Services	3%	22%
First Responder Rehabilitation	3%	19%
Vector Control	3%	17%
Patient Reception Center	2%	22%
Veterinary or Animal Response	2%	21%
Veterinary Services	2%	17%
Pharmacy Support	2%	17%
Disaster Resilience	2%	17%
Search and Rescue	2%	16%
Radiological Community Reception Center	1%	23%

n=453

Note: "Developed" includes MRC units reporting the capability was developed prior to calendar year 2024 OR newly developed/updated in calendar year 2024.

FIGURE 20: *SUPPORT FROM AGENCIES/ORGANIZATIONS*

	Sponsoring Organization	Other Local Government	State Agencies	State or Local NGOs	Federal Agencies
Material resources	72%	25%	50%	21%	26%
Leadership	72%	20%	46%	10%	24%
Leadership	70%	17%	36%	13%	13%
Training	67%	43%	67%	39%	50%
Funding	54%	8%	43%	9%	43%
No support	8%	40%	11%	48%	24%

n=423-270

FIGURE 21: *MRC UNIT PARTNERSHIPS*

Types of Organizations	No Relationship	Written Agreement	Joint Training Activities	Response Partner
Local Emergency Management Agency	8%	17%	57%	77%
Local Health Department	7%	26%	59%	76%
Healthcare Coalition	19%	14%	51%	59%
Fire or EMS	21%	8%	49%	57%
State Emergency Management	23%	8%	41%	57%
Police or Sheriff Department	27%	7%	40%	54%
Hospital or Health System	26%	11%	41%	51%
Another MRC Unit	14%	12%	54%	46%
American Redcross	27%	21%	34%	45%
Citizen Corps or CERT	28%	6%	35%	35%
Educational Institution	36%	14%	39%	33%
Federal Agencies	40%	3%	31%	32%
Faith-based Organizations	53%	5%	21%	30%
Longterm Care	55%	7%	21%	27%
Animal Health	61%	3%	13%	23%
Pharmacies	67%	3%	8%	20%
NDMS	60%	1%	10%	11%
HOSA	53%	3%	15%	9%
Tribal Health Department	35%	2%	6%	8%

n=413-464

Note that the proportion of respondents selecting N/A for each organization type is not displayed.

2024 EDITION

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TO VOLUNTEER WITH THE MEDICAL RESERVE CORPS OR FIND THE NEAREST MRC UNIT VISIT:
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