

Volunteerism

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GOAL

The goal of this chapter is to define the role of the volunteer in disaster nursing.

OBJECTIVES

At the completion of this chapter, the reader will:

1. List the competencies needed to be a volunteer disaster nurse.
2. Apply these competencies to volunteer disaster nursing.
3. Analyze the various types of volunteer disaster response at the local, state, and national levels.
4. Understand what is involved in preparing for and responding to a disaster.
5. Define the recovery phase of volunteer disaster response.

Key Terms

- Disaster competencies
- Volunteerism
- Types of disaster responses
- Local disaster responses
- State disaster responses
- Federal disaster responses
- Preparing to respond
- Recovery

Introduction

In Chapter 1, a broad look at the nature, definition, and level of response helped us to understand what disaster nursing encompasses. In Chapter 2, we will look at volunteerism in disaster response, focusing on the role of a nurse volunteer in a disaster.

Disaster nursing fulfills a critical component of the health and medical emergency response, much as in common day-to-day health operations. This disaster nursing component applies directly to both the healthcare employee and the healthcare volunteer. The following chapter will address some of the competencies related to disaster nursing, especially in the context of the volunteer, throughout multiple phases of disaster response, including the preresponse or preparedness phase, during the response, and the postdisaster and response phase. These competencies will be woven throughout and will describe those functions that need to be considered both by the organization that recruits, as well as by the individual who hopes to assist in the response. A brief introduction to these competencies follows through works of the Medical Reserve Corps program and other sources (Center for Health Policy, 2004; Nursing Emergency Preparedness Education Coalition, 2003; Hospital Core Competency Subcommittee, 2004).

The Medical Reserve Corps (MRC) program was developed through the Surgeon General's office following the 9/11 terrorism attacks and will be explained in detail later. Reacting to the need to coordinate function of the program across the country, the program developed a core competencies matrix that illustrates general emergency response roles (Office of the Surgeon General, 2007a). This matrix is to be used by MRC units to further develop their teams and shape the individual volunteer experience so that a degree of cohesiveness can be inserted into the national model. Its tenets include considerations for personal safety, health, and preparedness; roles and responsibilities for volunteers; and overviews of public health activities and incident management principles.

Competencies and Volunteering in a Disaster

A more generic set of basic disaster competencies that any health responder, whether volunteer or paid, should appreciate include having a thorough understanding of the command structures to which one would report; knowledge of general roles and responsibilities, as well as policies and procedures; recognition of an emergency situation and its precipitators; familiarity with backup communication systems and constructs that would be employed; an understanding of the utilization of personal protective equipment (PPE) and other health and safety precautions; and a basic understanding of weapons of mass destruction (WMD) and chemical, biological, radiological, nuclear, and explosive (CBRNE) terrorism. All responders should have an understanding of the different types of terrorism and how to respond adequately to the differing types. Medical personnel should have a basic understanding of what various treatments are required for each type of terrorism, how casualties may present, and what plans are in place for dealing with these casualties, including decontamination procedures and mass medical triage plans.

Any disaster involving a health or medical response element will tax the normal function of the medical community, as discussed in Chapter 1. This has been

evidenced in recent responses to Hurricane Katrina, the attacks of September 11, 2001, the sarin gas attacks in Tokyo, the first World Trade Center attack in 1993, the Oklahoma City bombing, and so on. Indeed, even small-scale responses will produce a significant surge and stress on local and regional responses.

Neither governmental public health nor private-sector healthcare agencies have much surge capacity inherently built into the system. Mutual aid agreements among these institutions and increased regional collaboration are two ways that these groups have added some depth to their response structure, but true surge capacity can only be reached by having additional local personnel to augment the response. This is most clearly the case in scenarios wherein regional sharing might not work well (i.e., events that drain resources at a similar rate throughout multiple jurisdictions, such as pandemic influenza scenarios or large-scale regional responses such as those found with Hurricane Katrina or the 1993 flooding of the Mississippi River). This additional response can and often does come from local citizens with special talents and skills who volunteer their services in a disaster.

The willingness of volunteers to respond, especially in times of crisis, can be overwhelming at times. For example, over 30,000 volunteers flooded into the New York City area after the 9/11 attacks to assist, far beyond any governmental agency's ability to handle, especially when these volunteers are not trained in disaster response. People want to help and will most definitely present themselves to lend assistance during a crisis. Fortunately, the emergency response volunteering process is improving over time, consistently resulting in a more seamless process.

Types of Response: Who Might Respond

Several volunteer organizations have arisen since the September 11th attacks, mostly due to federal preparedness grant monies that have been issued to state and local governments across the country. One such volunteer organization developed after the 9/11 attacks is the MRC Program (Office of the Surgeon General, 2007b), which is housed under the newly crafted Citizen Corps (Federal Emergency Management Agency, n.d.) and U.S.A. Freedom Corps (n.d.) programs. MRC units are developing all across the country to meet the expected surge needs, as well as bolster the day-to-day activities of public health by strengthening the overall public health infrastructure of local communities. Education, training, response gear, and other resources are available to these teams through the federal funding. Composition of MRC units varies widely, by design, to reflect local community needs, although similar preparedness goals run pervasively throughout the groups. For example, at the time of this printing, Illinois had 38 MRC units, with many local health departments (LHDs) in Illinois exploring this option as a way to bolster their response plans.

All MRCs seek nursing and other medically trained personnel, and most recruit clerical staff to assist with paperwork and logistics. One of the biggest missions that LHDs enlist nurses for is the Strategic National Stockpile (SNS) implementation.

Through this response, federally stockpiled vaccines, drugs, and other medical supplies can be sent to local governments for dispensing to the public in a response to a mass epidemic such as an influenza pandemic or an act of bioterrorism such as anthrax. Nurses have many roles in assisting at local dispensing operations, whether through physically dispensing medicines or vaccines (under orders of the local physician or pharmacist or under suspension of licensing rules and regulations in a disaster and when a physician is not available), providing patient education to the affected public at the dispensing site, screening individuals before entering the clinic, helping discern the appropriate medication for an individual to use (based on the patient's possible contraindications and potential drug interactions), or by providing a clinical consult for the patient. These potential roles will vary from area to area, based upon planning models and the degree of training that personnel will receive, in addition to the direness of the scenario.

In addition to the local disaster health missions listed above, nursing personnel are also needed to support mass care operations, including sheltering of impacted individuals or mass treatment of the injured from a mass casualty incident. MRC volunteers from areas impacted by the 2004 and 2005 hurricane seasons helped their communities by filling in at local hospitals, assisting their neighbors at local shelters, and providing first aid to those injured by the storms. American Red Cross nurses and responders may also be deployed to assist with a response (ARC, 2007a, b). Congress chartered this quasi-governmental organization in 1905 to assist in disaster relief efforts domestically and internationally, and nurses have played a major role since its inception.

The SNS also contains federal medical stations (FMS) or field hospitals that are for use by local and state governments when resources have been overwhelmed and additional noncritical hospital care is necessary. It is likely that local and state responders would be used to assist in staffing an FMS, including local ARC and MRC volunteers or other statewide volunteer teams.

Local and State Response

As presented in Chapter 1, when a disaster occurs at the local or state level, different types of responders are called out. Some of these may be volunteers. Regional volunteer groups were discussed in the previous section and include MRC, Community Emergency Response Teams, and local ARC volunteers. Many states have statewide volunteer responders as well. The ARC has a state-level response, when a local chapter is overwhelmed. Other types of healthcare professionals volunteer with statewide agencies, as well. This section will explore one state's volunteer response groups to show you how such a statewide volunteer response might be organized.

The Illinois Medical Emergency Response Team (IMERT, n.d.) and Illinois Nurse Volunteer Emergency Needs Team (INVENT, n.d.) are two Illinois-specific state volunteer response teams, coordinated at the state level, that assist local response as well as deploy across state borders via Emergency Management Assistance Compact

(EMAC) responses. IMERT is a statewide volunteer response team that can provide support for some of the acute medical functions associated with mass casualty incidents and other large-scale medical issues, like those from Hurricane Katrina.

INVENT is similar to IMERT, although it is generally deployed to augment the first responder capability of IMERT by providing a secondary follow-up supportive response. INVENT is a volunteer group of RNs from a variety of backgrounds trained to respond and provide nursing care during state disasters, emergency situations, and prolonged recovery efforts. INVENT, being a secondary response contingent, largely serves to assist IMERT or other first response teams in field response efforts, thereby creating a tiered response capability. Similarly, INVENT would be able to enhance local health department capacity for mass immunizations or medication dispensing and assist with localized hospital surges and/or staffing at alternate care sites, such as locations established by hospitals when a particular facility is overwhelmed or compromised.

Both IMERT and INVENT teams have been deployed to confront large-scale disasters and emergencies that overwhelm local personnel resources. For example, IMERT and INVENT assisted with a special needs shelter to meet the medical need that surpassed the capabilities of the local American Red Cross shelters and local health providers during ice storms that affected central and southern Illinois in 2006. Together, IMERT and INVENT have about 500 nurses and are always recruiting more.

In the event of an outbreak scenario or disaster, there is always a high demand by the public for information about the disaster and response. The Illinois Poison Control Center has phone banks designed to field questions from the public and from clinical providers to serve as a hotline for information sharing in the event of a pandemic or other emergency. INVENT nurses are currently being trained to staff these phone banks, and a recent drill tested the state's capabilities to execute an information hotline function. Over a 4-hour time span, the capability of the system to handle a surge in calls from the public was explored. Most of the calls (85%) were handled immediately by an INVENT nurse. Lessons from the drill are being used to adjust automated messages, build capabilities to field inquiries from the public and healthcare providers, and direct callers to useful information. Other potential uses for INVENT include staffing megashelters (when regional resources have been exhausted and state facilities need to be established), that would likely be state-operated facilities, designed to execute a well-defined scope of care and manage noncritically injured or ill patients.

Federal Response

One of the first FMS deployments was to Louisiana for the Hurricane Katrina response. This response was partially staffed by IMERT volunteers who actually assumed command of the FMS in New Orleans because the first responders in that state were overwhelmed and unable to respond themselves. The FMS contains all

the necessary components for a very basic field hospital, but does not deploy with sufficient personnel to staff it; thus, volunteer staff must be brought in to support the complement of medical supplies. This solution works well when a hospital becomes overwhelmed with patients or becomes environmentally or structurally compromised by the effects of a disaster. It is likely that the FMS would constitute much of the physical composition of the alternate care sites or mega-centers that could be staffed by volunteer response teams such as IMERT and INVENT or local responders.

Federal medical and nursing teams are also available and are assembled through the National Disaster Medical System (NDMS) (U.S. Department of Health and Human Services, 2007). Nurses have many opportunities to join different teams within the NDMS and have their licensure and certification recognized by any state to which they respond, in addition to federal protection in malpractice suits. The two main NDMS teams that utilize nursing professionals are the Disaster Medical Assistance Teams (DMATs) and the National Nurse Response Team (NNRT).

Volunteer groups will need, in conjunction with local, state, and federal authorities, to determine the roles they will have in local Hospital and Health Emergency Response Plans and work to coordinate the plan development, while familiarizing themselves with the incident management procedures and techniques of the volunteer organization and other responding agencies (Toner et al., 2006). Hospitals are required to test their surge capacity plan annually via either a surge in volunteers or a surge in victims from an emergency, and a partnership with the leadership of a volunteer disaster team should be forged with the hospital management to utilize these surging volunteers in a response (American Medical Association & American Public Health Association, 2007). Clinical personnel, namely nurses, will have an important role in assisting in this plan development, as well as bringing the plans to life by being part of the actual response.

Preparing to Respond

In 1995, Rebecca Anderson, an LPN, was killed while responding to the Oklahoma City, Murrah Federal Building bombing. She heroically worked to save lives immediately after the blast, but was struck by falling debris and ultimately died days later (Oklahoma City National Memorial and Museum, 2006). Her courageous yet tragic death serves to remind any responder of the importance of protecting oneself and ensuring his or her health and safety, as well of that of fellow responders. Personal and family plans are as important for the responder and the volunteer as for those of the responding institution: With no capable responders, an agency's response plan is nothing. Ensuring the safety of the responder ensures there will be one less victim and more help for those in need.

All levels of government are working to provide simple plans so the average citizen can respond better to an emergency. The Red Cross has developed these plans for some time (ARC, 2007a). Illinois recently activated its emergency response Web

site for the public, complete with a link that can be added during a response to provide important updates to the public (State of Illinois, 2007). The federal government developed a comprehensive website that covers various levels of preparedness for individuals and businesses (U.S. Department of Homeland Security, n.d.) as well as a look at WMD and CBRNE considerations, and also utilizes a specific website for pandemic influenza activities that shares information to the public (U.S. Department of Health and Human Services, n.d.).

It is very much in the best interest of the volunteer responder to pre-affiliate with a response organization before a disaster for a number of reasons. Joining a team that is a good fit will align the responder with the right type of response that fits his or her scope and skills. Additionally, an affiliated responder will be more capable of responding in an appropriate fashion and more likely to be included in the response element because he or she will have had credentials verified, received proper training, and will be more familiar with fellow volunteer responders as well as the governmental or healthcare-sector employees working alongside the volunteer through exercises and orientation meetings. Therefore, it behooves the potential volunteer responder to examine the different types of teams that are available and the proper team for him or her to join. Joining a volunteer team is an important and sought after decision, but it should be an informed decision. Some considerations one should ask are included in Table 2-1. Answering these questions will assist the potential volunteer in deciding which program to join and whether or not volunteering is a good idea.

During the Response

Medical personnel in general and nursing professionals specifically have a huge role in a disaster medical response, whether they are employed by a responding agency or

TABLE 2-1 QUESTIONS TO CONSIDER BEFORE VOLUNTEERING

Lots	Some	Little	Questions to Consider
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How involved do I want to become?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do I want to be deployed frequently and receive lots of training?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do I want to respond outside of my immediate area? Outside of my county? State?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would a deployment hurt my family life?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do I need to be paid during any deployment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the volunteer team I like cover liability issues?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How could this affect my current employment?

Source: Adapted from Peterson, 2006.

are responding in a volunteer capacity. For instance, if a human influenza pandemic occurs, as patients begin to present to their doctors and to medical facilities for treatment, it will be up to the clinicians to report cases to public health authorities in order to direct the management of the response. The same conditions apply for food-borne outbreaks and generally any other large infectious disease or disaster response involving health issues or injuries. As mentioned earlier, a surge in caseload and a complimentary drain on resources is to be expected both in the outbreak scenario as well as a mass casualty incidence.

Beyond surveillance, during a major outbreak, practitioners may be forced to implement isolation of infected patients, conduct infection control procedures, and develop PPE policies. Nurses and other clinicians in medical settings will be relied upon to execute these interventions. As frontline personnel directly engaging the ill, nurses will also need to protect themselves and then extend stringent infection control standards when caring for each other and for their patients. This was clearly evidenced in the SARS outbreaks of 2003 in Asia and Canada. Infection control practices and the use of PPE seemed to be the most reliable way to interrupt disease spread and protect those most directly affected since a solid treatment for this novel virus had not been developed (CDC, n.d.). These practices would need to be employed for any major outbreak. Proper PPE and infection control precautions would naturally need to be applied to any mass casualty response.

In the event of a pandemic or other emerging infectious disease outbreak, it is likely that a surge in caseload will quickly overwhelm the public health system. For example, clinic and hospital settings are expected to be swamped with both ill patients, as well as the “worried-well.” LHDs will not necessarily see patients in their offices and clinics, but mass medication and vaccination campaigns will require immense staffing demands. To address the need for medical materials, public health officials have been working to stockpile resources, both in the aforementioned SNS and in state and local caches. However, to prepare for the need for additional personnel, teams of volunteer health professionals must be ready to augment the public health emergency response.

Similarly, an influenza pandemic or other infectious disease outbreak will weigh heavily on the medical community and especially on hospitals (Buehler et al., 2006). The National Response Plan speaks specifically to this issue, and a pandemic scenario is prioritized via the list of National Planning Scenarios. History has taught us about the need for this type of plan: The 1918 pandemic was characterized by such an exceptional surge on the medical system that many lay persons were conscripted to assist with the medical response and received a crash course in medical therapy. These individuals worked closely alongside the few nurses who were healthy and available, taking direction from the nursing staff and supporting medical and nursing care in what ways they could. This particular emergency illustrates

the expandable role of the disaster nurse responder. Depending on the severity of the response, nurses may be asked to fill nontraditional roles.

EMAC, briefly mentioned earlier, is a mutual aid agreement, adopted by all 50 states. This agreement allows for rapid resource sharing and state assistance among states during governor-declared emergencies. Through EMAC, states are allowed to request anything they need, for any specific response; the requesting state pays for the response costs of the responding state (National Emergency Management Agency, 1995–2007). Previously, IMERT's response and deployment to Hurricane Katrina was mentioned as being a response to the EMAC agreement between Louisiana and Illinois. Once the agreement was secured with a specified response package selected by Louisiana, IMERT was deployed and Louisiana reimbursed Illinois for its response efforts.

Receiving a surge of volunteers from outside of the affected area's jurisdiction can be a challenge in itself, as was dramatically seen in the response to the World Trade Center bombings in 2001. As human resources swarm into an affected area, providing services for those individuals can be a challenge. The receiving entity must establish reception and processing centers to receive these responding teams efficiently and effectively. EMAC frees up many of the issues associated with license portability (an Illinoisan being able to use his or her Illinois nursing license to do the necessary response in an emergency capacity in Pennsylvania), credentialing, liability, and so on.

WMD and CBRNE agents need to be considered in any disaster response, including those responses that seem benign. Historically, initial attacks may be followed up with secondary devices specifically set to detonate and harm the first responders. These devices must be accounted for and considered throughout the response. Generally, volunteers should never be allowed to enter what is considered the "hot zone" or the immediately impacted area, but there are occasions where there are no highly recognizable zones or a volunteer is the first responder on the scene. These situations need to be approached with additional caution. Learning how to deal with such possibilities should be incorporated into any emergency management and disaster volunteer training curriculum.

Lastly, it is critical that during the preparedness and disaster response orientation phase that a responder, paid or volunteer, makes his or her capabilities clear to the response teams, whether volunteer or governmental. Recent disasters are filled with anecdotal evidence illustrating situations wherein individuals presented to assist with the response, but were placed into situations unfit for them based upon their experience and degree of comfort. This is especially troublesome and more probable in diverse disciplines like those of physicians and nurses. In a disaster situation, one may be compelled to assist in any way possible, but there is a huge difference in skills and knowledge between a trauma nurse specialist and a nurse who works in public health providing chronic disease preventative education. Based on

the circumstances of the event, it is easy for someone to be placed in a situation that could quickly overwhelm him or her, and caution should be exercised both by the responding agency and by the volunteer when the agency is tasking individuals with response missions.

After the Response: The Recovery Phase

This period is probably the most important portion of the response, especially for the volunteer who might not regularly be exposed to disaster outcomes, including mass illness or death or exposure to body parts. Responses to these unusual and often disturbing experiences can have significant mental health repercussions, including development of post-traumatic stress disorder, substance abuse, hypertension, depression, sleep disorders, panic attacks, memory loss, and other physical, mental, and behavioral problems (Hammond & Brooks, 2001). Critical incident stress debriefing (Chapter 8) must be carefully conducted, including the timing of when the counseling is employed (Campfield & Hills, 2001). Regardless of the timing of the intervention and counseling, it is clear that critical incident stress management (CISM; Chapter 8) must be conducted, and it must be conducted by trained individuals. Without some degree of counseling, the volunteer or paid responder runs the risk of mentally reliving the disaster experience, potentially harming the person's health and livelihood over time.

As frontline responders, nurses will likely be exposed to the more gruesome effects of any disaster response. The SARS outbreak affected healthcare workers at a higher incidence than other groups, because of the proximity of the workers to the pathogen and the ways the virus was spread. As a result of situations such as the SARS outbreak, healthcare workers are in a cohort that is more likely to need counseling both immediately afterwards and long term, especially if a significant amount of healthcare personnel are injured, infected, or killed by a disaster's effects. Therefore volunteer response teams should look to include CISM into their response plans and seek ways in which this type of counseling can be provided to the volunteer team's responders. If a responder is on a team without any observable CISM program, this should be brought to the attention of the team's leadership so that it can be adequately addressed, and this important component can be provided for.

Go Forth and Volunteer

Volunteer teams are actively recruiting and lining up personnel before an emergency hits; the response goes more smoothly when volunteers are already pre-loaded into the response apparatus rather than showing up cold. If you have ever watched a disaster response on TV and wanted to be there on the ground helping but did not know how to get involved, you should begin exploring the types of teams that are out there and talk to the coordinators of the programs to see what role or team might be a good fit for you. Volunteering for disaster nursing teams is

an old and time-honored tradition in nursing, going back in this country to Clara Barton in the Civil War and starting the American Red Cross as her response to the needs of soldiers. One never knows when a disaster will strike, but one can be prepared, as Barton wanted nurses to be, to help those caught in a disaster—those who might even include the nurse and his or her family. Being prepared means being safer and knowing what to do when disaster strikes.

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