

APPLICATION FOR MEMBERSHIP

INSTRUCTIONS: FILL IN ALL QUESTION COMPLETELY, PRINT ALL INFORMATION IN BLUE OR BLACK INK. ALL QUESTIONS MUST BE ANSWERED COMPLETELY AND TRUTHFULLY. INCOMPLETE APPLICATION OR ANY MISPRESENTATION IS CAUSE FOR REJECTION. USE THE BACK OF THE FORM IF ADDITIONAL SPACE IS NEEDED.

Applicant Name (Last, First, MI): _____

Sex: M / F SS#(optional) _____

Mailing Address _____

Street Address _____

What Municipality do you live in? _____ Twp. / Boro

How far (in miles) do you live from the squad building? _____

Telephone Number-Home _____ Best time to be contacted? _____ AM/PM

Telephone Number-Work _____ Can we contact you at work? Y / N

Alternate Telephone Number (Specify type) _____

Email Address _____

Do you currently hold a valid Driver's License? Y / N

If yes, what state? _____ D.L. # _____

Current point total _____ Date of last moving violation _____

Have you ever been convicted of an indictable offense/crime? Y / N

Do you belong to a volunteer organization? Y / N

If yes, list organization and dates of service:

_____ From _____ To _____
Reason for leaving?

May we contact the organization as a reference? Y / N

_____ From _____ To _____
Reason for leaving?

May we contact the organization as a reference? Y / N

_____ From _____ To _____
Reason for leaving?

May we contact the organization as a reference? Y / N

Have you ever been rejected or dismissed from membership from another first aid squad or volunteer organization? Y / N

If _____ yes, _____ explain

Are you committed to devoting the time to complete required training? Y / N

Are you committed to attending all required meetings and drills of the squad as well as taking a required twelve hour duty shift and a Saturday shift once every six weeks? Y / N

Do you currently hold any valid first aid or any other specialized training certifications? Y / N

If yes, list with date of expiration

_____	EXP _____
_____	EXP _____
_____	EXP _____
_____	EXP _____

References: Please list three non Related people over the age of eighteen (18) that you known for a period of two years or greater, that we may contact.

Name _____ Telephone # _____

Address _____

How long have you known this person? _____ Relationship _____

Name _____ Telephone # _____

Address _____

How long have you known this person? _____ Relationship _____

Name _____ Telephone # _____

Address _____

How long have you known this person? _____ Relationship _____

Emergency Contact (all applicants):

Name: _____ Relationship _____

Telephone Number _____ Alternate Number _____

Declaration (all applicants):

I, _____ hereby make application for membership to the South Bound Brook First-Aid Squad, Inc. If accepted, I agree to abide by the constitution and the by-laws of the said squad. I understand that falsification of any fact on the application id just cause for immediate refusal of acceptance or dismissal from the squad once such information is made known. I furthermore agree to, by signing below and submitting this application for review, allow the South Bound Brook Police Department to perform a criminal and driving background check on me.

Signature _____

Date _____

Applying for (to be completed by Membership Committee):

EMT/Riding

Driver Only

Non-Riding

Membership Application
Medical Exam

Note to Examining Physician:

This individual has applied for membership to the South Bound-Brook First-Aid Squad. As a member he/she may be exposed to situations, which put high demands on both body and mind. Emergency Medical Technicians (EMTs) and ambulance drivers are often called upon to lift and transport patients in dangerous /awkward situations – i.e. downstairs, out of auto accidents or just out of bed.

It is important that our service do not cause further injury to our patients, as well as, to our membership.

We ask that you examine this individual with these types of activities in mind and note areas of concern, so we may keep everyone safe, healthy and injury free.

Membership Application - Medical Exam

This document is to be filled out and signed by a licensed physician in the State of New Jersey and to be returned with your membership application. Please ensure this form is filled out in its entirety.

Name: _____

Age: _____ Height: _____ Weight: _____ Corrected Eye Sight:
_____lt_____rt

Hearing: _____ BP: _____ Pulse: _____
Resp _____

Does the applicant have any apparent disabilities with? Please explain any items checked/

___Heart

___Lungs

___Joints

___Feet/Legs

___Hands/Arms

___Spine

___Hernia

Has the applicant ever suffered from any injury? Yes ___ No ___ If yes, when and what please explain

Remarks:

I hereby certify that, as a practicing physician in the State of New Jersey, the applicant is free from any acute or chronic disease and has no physical defects that will inhibit their ability to perform the duties of an Emergency Medical Technician or an ambulance driver.

Doctor's Name _____ (print name)

Office

Address

Phone Number _____

Date

examined

Doctor's signature _____

Rejection based on:
