

Lodi Volunteer Ambulance Rescue Squad Inc

72 Kimmig Avenue/ P.O. Box 299

Lodi, New Jersey 07644-0299

Business: (973) 546-3488 ♦ Fax: (973) 860-0859

APPLICATION FOR MEMBERSHIP

Last Name: _____ First Name: _____

Social Security#: ____/____/____ DOB: ____/____/____ Age: _____ Sex: Male Female

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

CONTACT NUMBERS

Home :_(_____) _____ Work: __ (_____) _____

Cell: __ (_____) _____ E-Mail: _____

DRIVER LICENSE INFORMATION

Driver's License #: _____/_____/_____ Expiration Date: ____/____/____

Do you have any moving violations or accidents? YES NO

If Yes, Please explain: _____

QUESTION INFORMATION

Have you ever been arrested or convicted of a crime? YES NO

If Yes, Please explain: _____

Do you have any medical conditions/disabilities that would prevent you from performing your duties as a member of the Ambulance Corps? YES NO

If Yes, Please explain: _____

Do you have any First-Aid training? YES NO

IF Yes, Please explain: _____

Have you ever been a member of any Paid/Volunteer EMS services? YES NO

If Yes, Please list where, whether you are still a member or reason of leaving: _____

EMPLOYMENT/SCHOOL INFORMATION

Name of Employer/School: _____

Address: _____ City: _____ Zip Code: _____

Name of Supervisor/Student Counselor: _____

Phone number of Supervisor/Student Counselor: ____ (____) _____ Position/Grade: _____

EMERGENCY CONTACT INFORMATION

1. Last Name: _____ First Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone #1 __ (____) _____ 2. __ (____) _____

2. Last Name: _____ First Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone #1 __ (____) _____ 2. __ (____) _____

NOTE: These persons will ONLY be contacted in case of any emergency.

RELEASE FOR BACKGROUND CHECKS

By my signature below, I hereby authorize the **Lodi Volunteer Ambulance Rescue Squad Inc and/or authorize agent** to perform the necessary criminal records background checks and motor vehicle records check. I do hereby release and hold harmless the **Lodi Volunteer Ambulance Rescue Squad Inc and/or authorize agent** from all and any action that may arise from such a search.

Signature of Applicant

_____/_____/_____
Date

If you are under the age of eighteen (18) and wish to join the **Lodi Volunteer Ambulance Rescue Squad Inc**, parental permission is **REQUIRED**. A parent or legal guardian **MUST** sign below and agree to the above background checks otherwise this application is incomplete and **WILL NOT** be processed.

Signature of Parent/Legal Guardian

_____/_____/_____
Date

Phone# ____ (____) _____

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Equipment Registration

I hereby acknowledge that I have received the following equipment/items from the Lodi Volunteer Ambulance Rescue Squad, Inc

Last Name: _____ First Name: _____

- Pager Serial #: _____
- Class "B" Duty Uniform staff shirt with the Lodi Volunteer Ambulance Rescue Squad, Inc logo
- Class "B" Duty Uniform six (6) pocket BDU military style pants
- Winter Jacket
- Class "A" Dress Uniform – Long sleeve shirt
- Class "A" Dress Uniform – Short sleeve shirt
- Class "A" Dress Uniform – Pants
- Class "A" Dress Uniform – Belt
- Class "A" Dress Uniform – Tie
- Class "A" Dress Uniform – Tie Clasp
- Class "A" Dress Uniform – White Dress Uniform Gloves
- Class "A" Dress Uniform – Name Plate
- Class "A" Dress Uniform – Collar pins (2 caduceus)
- Lodi Volunteer Ambulance Rescue Squad, Inc Badge ID Badge #: _____
- Constitution & By-Laws Manual
- Policies & Procedures Manual

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MEDICAL RELEASE

Date ____/____/____

To Whom It May Concern:

_____ is a perspective member of the Lodi
(Member Name)
Volunteer Ambulance Rescue Squad, Inc. As a member of our organization, he/she will have to complete physically demanding tasks, including but not limited to, lifting and carrying patients and equipment, performing cardiopulmonary resuscitation, and other demanding tasks.

I, _____, have seen _____ and understand that he/she is a perspective
(Physician Name) (Member Name)
member of the Lodi Volunteer Ambulance Rescue Squad, Inc. He/She is physically capable of fulfilling the duties required by your organization.

Physician Signature

Physician Name Printed

Address

City, State, Zip

Telephone