

Southampton Village Volunteer Ambulance

Membership Application

Membership Applicant:

On behalf of the Members of the Southampton Village Volunteer Ambulance, I would like to thank you for expressing interest in serving your community by joining our organization. Before joining, it is necessary for you to complete and submit certain information for our records.

Please complete the enclosed Membership Application and return it to:

ATTN: Membership Committee Southampton Village Volunteer Ambulance PO Box 832 Southampton, NY 11969-0832

In addition to the membership application, please include the following:

- A letter of recommendation from two persons who are not related to you
- A copy of your valid New York State Driver's License
- (OPTIONAL) Copies of any certifications relevant to our organization

To avoid delay in your membership approval, and to keep your information confidential, please mail this application to the above address. **Please do not hand deliver, fax, or email this application.**

Upon receipt of this application, our Membership Committee will contact you to set up an interview. After that, we will conduct a background check and present your application to our members for a vote at one of our monthly membership meetings, which usually take place on the fourth Monday of each month. For more information, please visit our website, www.VillageEMS.org, or email our Membership Committee at Apply@VillageEMS.org.

Once again, thank you for your interest in serving your community!

Sincerely,

Chief of Department Southampton Village Volunteer Ambulance

Personal Information and Relevant History

Please complete the following boxes as accurately as possible. Please draw a line through the section if it does not apply.

Name	Gender Date of Birth
Social Security No. Marital Status	Drivers License No. State of Issuance
Home Address	City, State, Zip
Mailing Address (if different)	City, State, Zip
Cell Phone Cell Provider	Home Phone Work Phone
() -	() - () -
Current Email Address	
Emergency Contact Person	Phone Number Relationship
	() -
	7
Educational History	Military History
High Calcasts	Branch:
High School:	Honorable Discharge Dishonorable Discharge
College:	(circle one)
	Discharge Date://
Emergency Services History Please list any (volunteer or paid) EMS or Fire	Diagon list contact numbers for those agencies. If
Departments that you have been a member of or	Please list contact numbers for these agencies. If you prefer that we do not contact them, please
are currently a member of within the last five years:	leave the space blank.
Foreign Languages	Please List
Are you fluent in any other languages other than English?	
Criminal History Please list any criminal convictions in the past ten	Have you ever been convicted of any subdivision of
years:	Have you ever been convicted of any subdivision of Section 1192 of the NYS Vehicle and Traffic Law
	within the last 10 years? (DWI or DWAI)?
	YES NO

Medical / Physical Eligibility Do you have any health or physical deficits that would prohibit you from the following? Ability to communicate effectively via telephone and radio equipment Ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance) Ability to interpret oral, written and diagnostic form instructions Ability to use good judgment and remain calm in high stress situations Ability to be unaffected by loud noises and flashing lights Ability to calculate weight and volume ratios Ability to read English language, manuals, and road maps Ability to accurately discern street signs and addresses Ability to interview patients, patient family members, and bystanders Ability to document, in writing, all relevant information in prescribed format in light of legal ramifications of such Ability to converse, in English, with coworkers and hospital staff with regard to the status of the patient Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care Ability to bend, stoop and crawl on uneven terrain Ability to withstand varied environmental conditions such as extreme heat, cold and moisture Ability to work in low light situations and confined spaces Ability to work with other providers to make appropriate patient care decisions If so, please list: I certify that the information provided above is true and accurate to the best of my knowledge. I also understand that by signing this document, I give the Southampton Volunteer Ambulance permission to conduct a full background investigation and license check. Print Applicant Name **Applicant Signature** Date

Print Applicant Name

Applicant Signature

Date

Membership Committee Use Only

Probation Date

Full Member Date

Membership Committee Member

Date

Membership Committee Member

Date

Village Approval

Date