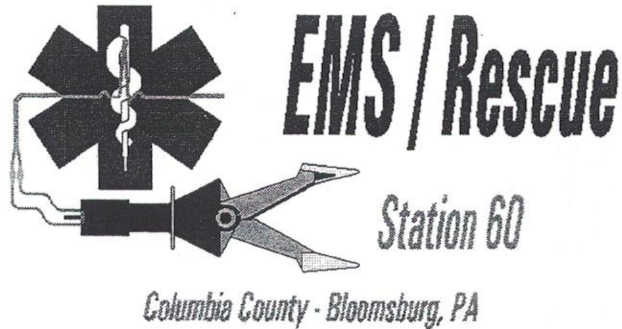
BLOOMSBURG VOLUNTEER AMBULANCE ASSOCIATION, INC.

307 East Main Street
P.O. Box 120
Bloomsburg, PA 17815
570-784-6237

Application for Membership



BVAA Members:

Please obtain the following information from any interested applicant. Remove this cover sheet and place in the trip sheet box. The information below will be used for follow-up purposes. Give the rest of the application to the applicant for completion.

Date: ____________________

Name: ____

Phone Numbers: Home: ____________________________

Cellular: ____________________________

Pager: ____________________________

School: ____________________________

Work: ____________________________

Bloomsburg Volunteer Ambulance
Application for Membership

Section 1-Applicant Demographics:

Name ______________________________
Address ____________ ________________
____
Date of Birth ________________________

Driver's License Number ________________________

Phone Numbers With Area Code

Home ________________
Cell ________________
School ________________

Exp. Date ________________

Certifications:	**Certification number**	**Course Completion Date**	**Expiration Date**
First Responder			
EMT			
Paramedic			
Health Professional			
CPR			
Haz Mat (min R&I)			
EVOC:			
Vehicle Rescue :			

Other Certifications:

____
____
____
____
____

Prior to your application being considered, Bloomsburg Volunteer Ambulance requires that a copy of Your certification be submitted with this application.

Signature:________________________________

Section 2-BVAA use

I hereby propose the above name individual for membership in the Bloomsburg Volunteer Ambulance Association

Proposing Member:________________________ **Date:**________________

PERSONAL RECORD

NAME : ____________________

ADDRESS: ____________________

HOME PHONE: ____________ CELL PHONE: ____________ PAGER: ____________

DATE OF BIRTH: ____________DRIVER LICENSE NUMBER: ____________

EMAIL ADDRESS: ____________________

EMERGENCY CONTACT: NAME:____________________

ADDRESS: ____________________

CONTACT PHONE NUMBERS: ____________________

ALTERNATE CONTACT PERSON IF UNABLE TO REACH ABOVE INDIVIDUAL:

NAME: ____________________

ADDRESS: ____________________

CONTACT PHONE NUMBERS: ____________________

PHYSICIAN: ____________ BLOOD TYPE: ____________

ALLERGIES: ____________________

CURRENT MEDICATIONS:

____

____

MEDICAL INSURANCE INFORMATION: ____________________

BENEFICIARY : ____________________

BENEFICIARY CONACT INFORMTION: ____________________

____

IT IS YOUR RESPONSIBILITY TO KEEO CURRENT INFORMATION ON FILE.
ANY CHANGES NOTIFY THE ECRETARY AS ON S POSSIBLE.
THUS INFORMATION WILL ONLY BE USED IN CASE OF
EMERGENCY AND WILL REMAIN CONFIDENTIAL.

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