



Whatcom County EMS & Trauma Care Council

General Council Membership -Agency Representative

Contact Information

Name: _____

Street Address: _____
Street Address *Apartment/Unit #*

City, State, Zip _____
City *State* *ZIP Code*

Phone: _____

Email: _____

Sponsoring District/Agency: _____

Are you a Whatcom County Resident? YES NO

Are you a Full Time or Part Time Employee? Full Time Part Time

Are you a Volunteer or Paid Employee? Volunteer Paid

Skills/Qualifications/Experience

Why are you seeking membership in the Whatcom County EMS/TC Council?

What do you feel you can contribute to the committee?

Agreement and Signature

I acknowledge that I have read and understood the WCEMSTCC bylaws. I understand the definition of a member in good standing and I hereby pledge that I will attend a minimum of four consecutive WCEMSTCC or committee meetings per fiscal year. In the event that I cannot meet this requirement, I understand that my voting rights are suspended until I attend two consecutive meetings. I further acknowledge that my membership may be revoked if the Council determines I have failed to promote or represent the organization appropriately.

Applicant Printed Name: _____

Applicant Signature: _____

Date: _____

Supervisor of EMS agency

I nominate this applicant to represent our agency through membership of the Whatcom County EMS & Trauma Care Council.

Supervisor Name Printed: _____

Supervisor Signature: _____

Date: _____

When application is complete, please submit:

Email: admin@WhatcomCountyEMS.com

Fax: 360-788-6492

Mail : Whatcom County EMSTC Council
PO Box 5125
Bellingham WA 98227