Hopatcong Ambulance Squad

PO Box 334, Hopatcong, NJ 07843

Volunteer Member Application

INSTRUCTIONS FOR COMPLETING THIS APPLICATION:

1. Print out this entire document.
2. Fill out the **APPLICANT INFORMATION** form (2 pages).
3. Sign and date the **RELEASE OF APPLICANT INFORMATION** form.
4. Have your physician fill out and sign the **PHYSICAL HEALTH RECORD** form (2 pages).
5. Return all forms to the following address:

Hopatcong Ambulance Service, Inc.
P.O. Box 334
Hopatcong, NJ 07843

Or

Scan and email the application to Recruiting@hopatcongEMS.org
(You will need to bring any forms with original signatures with you to an interview)

For questions or additional information call the Captain's Line at: (973) 770-0440 or email **contact@HopatcongEMS.org**

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APPLICANT INFORMATION (Page 1 of 2)

Please print clearly

Date: ____/____/____ If applying for DRIVER position check here: ___

How did you hear about us? _____

Last Name: _____ First Name: _____ Middle Initial: ___

Address: _____

Email Address: _____

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Date of Birth: ____/____/____ Social Security Number _____-_____-_____

Marital Status: _____ Number of children: _____

How long at present address? ___yrs____mon

If under two years list previous address: _____

Employer:_____ Phone: (_____)_____-_____

Address: _____

Supervisor: _____

If employed with above employer less one year list previous employer:

Employer:_____ Phone: (_____)_____-_____

Address: _____

Supervisor: _____

May we contact above employers? ___ Yes ___ No

Have you ever been convicted of any crime? ___ Yes ___ No

If yes, explain: _____

_____

Are you currently being charged with any crime? ___ Yes ___ No

If yes, explain: _____

Driver's License Number: _____ State issued: ____

Total points currently against driver's license: _____

Has your license ever been suspended? ___ Yes ___ No

If yes, explain: _____

Have you ever been convicted of a DWI? ___ Yes ___ No

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APPLICANT INFORMATION (Page 2 of 2)

List all other organizations, to which you belong, the length of time of membership and positions

Organization Name	From Date	To Date	Position

Have you ever been a member of a First Aid squad? ___ Yes ___ No

Squad Name: _____

Address: _____

Date of membership: From: ____/____/____ To: ____/____/____ Phone: (_____)_____-_____

Position(s) held: _____

List any certifications you presently carry and when they expire:

CPR: ____/____/____ First Aid: ____/____/____ EMT: ____/____/____ EMT-D: ____/____/____

EMT-P: ____/____/____ LPN: ____/____/____ RN: ____/____/____ MD: ____/____/____

Other: _____: ____/____/____ Other: _____: ____/____/____

List any other medical training you may have: _____

_____

Do you have any physical or learning disabilities: ___ Yes ___ No

If yes, explain: _____

_____

References (Name, relationship, phone number)

1. _____

2. _____

3. _____

Hours of availability

(List Days/Nights and Hours): _____

_____

Your acceptance as a member of this squad will be determined (in part) by your hours of availability and the need for members for those hours. Hopatcong Ambulance Service, Inc.

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RELEASE OF APPLICANT INFORMATION

I authorize investigation of all statements contained in this application and give any agency the permission to supply the Hopatcong Ambulance Service, Inc., with any information that they may deem necessary for my acceptance into said organization.

I understand that misrepresentation or omission of facts called for is cause for dismissal. Furthermore, I agree to abide by the Constitution, By-Laws, and Rules and Regulations as set forth by the Hopatcong Ambulance Service, Inc.

I also agree to return all equipment given to me should I no longer become a member of the Hopatcong Ambulance Service, Inc.

_____ Date: ____/____/____

Applicant Signature

_____

Print Name

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PHYSICAL HEALTH RECORD (Page 1 of 2)
(To be completed by a Physician)

Please be advised that duties may include responding to emergency calls at all hours of the day or night and in all weather conditions. Also, lifting weight could possibly exceed 125 pounds to chest level.

Applicant Last Name: _____ First Name: _____

AGE _____ HEIGHT _____ WEIGHT _____ COMPLEXION _____ EYESIGHT _____

BLOOD PRESSURE ____ Normal ____ Abnormal

Please check the appropriate area for any of the following symptoms which the patient now has of has had previously:

GENERAL

- ☐ Allergies
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Nervousness/Depression
- ☐ Neuralgia
- ☐ Numbness
- ☐ Tremors

MUSCLE & JOINTS

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Lower Back Pain
- ☐ Lumbago
- ☐ Neck Pain or Stiffness

PAIN OR NUMBNESS IN:

- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Legs
- ☐ Knees
- ☐ Spinal Curvature

GASTROINTESTINAL

- ☐ Colitis
- ☐ Liver Disease

EYES, EARS, NOSE & THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Failing Vision

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure

RESPIRATORY

- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Asthma

Check the following conditions if they apply to the patient:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Chorea
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (specify)

Any Communicable Diseases (Please List): _____

_____

PHYSICAL HEALTH RECORD (Page 2 of 2)
(To be completed by a Physician)

Is the Applicant presently on any medications? If so please list, and explain for what reason?

_____

_____

_____

Has Applicant ever suffered from a hernia? ___ Yes ___ No

Present Condition of the hernia: _____

Has Applicant ever suffered from back problems? ___ Yes ___ No

Present Condition back problems: _____

Remarks/Comments:

_____

_____

_____

I HEREBY CERTIFY THAT THIS APPLICANT IS PHYSICALLY _____ FIT OR _____ UNFIT

TO PERFORM THE DUTIES REQUIRED HEREIN AS A HOPATCONG AMBULANCE SERVICE MEMBER.

_____ Date: ____/____/____

Physician Signature

_____

Printed Name of Physician

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INVESTIGATING COMMITTEE REPORT

****FOR HOPATCONG AMBULANCE SERVICE INC. USE ONLY****

Last Name: _____ First Name: _____

Date Application Received: ____/____/____

Date Acted on by Committee: ____/____/____

Date Approved by Committee: ____/____/____

Date of Probation: ____/____/____

Date Accepted as an Active Member: ____/____/____

Comments of Committee:

_____

_____

_____

_____

_____

_____

Signatures of Committee Members:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____