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
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
APPLICANT INFORMATION (Page 2 of 2)

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

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>From Date</th>
<th>To Date</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Certification</th>
<th>From Date</th>
<th>To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>First Aid</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>EMT</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>EMT-D</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>EMT-P</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>LPN</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td><strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

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.
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
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 or has had previously:

<table>
<thead>
<tr>
<th>GENERAL</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Convulsions</td>
<td>Dizziness</td>
<td>Fainting</td>
<td></td>
</tr>
<tr>
<td>Nervousness/Depression</td>
<td>Neuralgia</td>
<td>Numbness</td>
<td>Tremors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCLE &amp; JOINTS</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Bursitis</td>
<td>Foot Trouble</td>
<td>Hernia</td>
<td></td>
</tr>
<tr>
<td>Lower Back Pain</td>
<td>Lumbago</td>
<td>Neck Pain or Stiffness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAIN OR NUMBNESS IN:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Arms</td>
<td>Elbows</td>
<td>Hands</td>
<td>Legs</td>
<td></td>
</tr>
<tr>
<td>Knees</td>
<td>Spinal Curvature</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Colitis</td>
<td>Liver Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYES, EARS, NOSE &amp; THROAT</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Deafness</td>
<td>Failing Vision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>Low Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td>Difficulty Breathing</td>
<td>Wheezing</td>
<td>Asthma</td>
<td></td>
</tr>
</tbody>
</table>

Check the following conditions if they apply to the patient:

<table>
<thead>
<tr>
<th>Alcoholism</th>
<th>Anemia</th>
<th>Arthritis</th>
<th>Chorea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Emphysema</td>
<td>Epilepsy</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Polio</td>
<td>Rheumatic Fever</td>
<td>Scarlet Fever</td>
</tr>
<tr>
<td>Stroke</td>
<td>Tuberculosis</td>
<td>Ulcers</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

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
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:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________