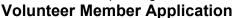


Hopatcong Ambulance Squad

PO Box 334, Hopatcong, NJ 07843





INSTRUCTIONS FOR COMPLETING THIS 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 captain@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 captain@HopatcongEMS.org



Hopatcong Ambulance Squad PO Box 334, Hopatcong, NJ 07843 Volunteer Member Application





APPLICANT INFORMATION (Page 1 of 2)

Please print clearly	
Date:/ Application for: Respon	nder EMT check one
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	
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

Organization Name	From Date	To Date	Position(s) Held
Have you ever been a member of a First A	Aid squad?	res No	
·			
Squad Name:			
Address:			1
Date of membership: From://_			
Position(s) held:			
ist any certifications you presently carry	and when they	expire:	
CPR:/ First Aid:	//	EMT://	EMT-D://
EMT-P:/ LPN:/_		RN:/	///
Other::::	/	Other:	:/
ist any other medical training you may h			
Do you have any physical or learning disa	hilities Ves	No	
			
f yes, explain:			
References (Name, relationship, phone n	umber)		
1			
2			
3			
Hours of availability (List Days/Nights and	d Hours):		



Print Name

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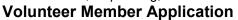
RELEASE OF APPLICANT INFORMATION

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



Hopatcong Ambulance Squad

PO Box 334, Hopatcong, NJ 07843





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. Assessment Date: / / 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: Alcoholism Dizziness/Vertigo Liver Disease **Allergies** Emphysema Lumbago **Multiple Sclerosis** Anemia Failing Vision Fainting/Syncope Anxiety/Depression Neck Pain Arthritis Foot Pain Numbness/Neuropathy Asthma **Rheumatic Fever Hearing Loss** Back Pain Scarlet Fever **Heart Disease Bursitis** Seizure/Epilepsy Hernia Stroke/CVS Chest Pain Hypertension Colitis **Tuberculosis** Hypotension **Difficulty Breathing** Knee Pain Please note any additional medical conditions that may impact this individual's ability to perform tasks on the Hopatcong Ambulance Squad:



Hopatcong Ambulance Squad PO Box 334, Hopatcong, NJ 07843 Volunteer Member Application





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