Montville Township First Aid Squad
137 Changebridge Road, Montville, NJ 07045
Post Office Box 416

Application Instruction Sheet

Thank you for your interest in joining the Montville Township First Aid Squad. We are very excited to welcome you. Please complete the 3 separate forms provided in this packet and complete the follow instructions:

1. General Application Form - please return this to the *First Aid Squad* by dropping it in our mailbox or emailing it to us at membership@montvillefas.org
2. Physical Sheet - please have this filled out by your *physician* and return it to the *First Aid Squad* by dropping it in our mailbox or emailing it to membership@montvillefas.org
3. Background Check - Please contact Officer Scott McGown at **973-257-4302** to schedule an appointment for fingerprinting as part of the background check process for **MTFAS**

Once all of these steps have been completed you will be contacted by the First Aid Squad and provided with further information regarding your onboarding process.

Thank you again for your interest in joining the Montville Township First Aid Squad.

MONTVILLE TOWNSHIP FIRST AID SQUAD
MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Last Name: First Name: Middle Initial:		
Date of birth:	SSN:	Occupation:
Cell Phone:	Home Phone:	
E-mail:		
Preferred method of contact - check one: Cell □ Home □ E-mail □		
Current address:		
City:	State:	ZIP Code:
Previous address (if at current for less than 5 years):		
City:	State:	ZIP Code:
Drivers Lic. #:	State:	Expires:

REFERENCES

Please provide 2 adult references other than family members:		
Name:		How long known?
Phone:	Relationship:	
E-mail:		
Name:		How long known?
Phone:	Relationship:	
E-mail:		

PREVIOUS EMS ORGANIZATION

Have you previously belonged to, or applied to another EMS organization? If so, which?

CERTIFICATIONS

Do have any certifications relating to EMS? (CPR/First Responder/EMT/Medic, etc.)
Please list them below and **provide copies with this application.**

1.	Expires:
2.	Expires:
3.	Expires:
4.	Expires:

AVAILABILITY

Are you available to serve during days? □, nights □, or both? □	
When are you available to start training?	Date:

SIGNATURE

If accepted, I agree to abide by the Constitution, By-Laws and Rules and Regulations of the squad for active membership. I understand that I must meet and maintain the educational standards required by the squad. I agree not to engage in any legal suit against the Montville Township First Aid Squad, Inc. (MTFAS) other than for personal physical injury sustained in the course of duty. I agree to a police background check for the purpose of safeguarding and protecting the public that I intend to serve.

I do solemnly swear and/or affirm that I, the undersigned, have completed this application for membership and that I shall live up to the purpose, ideals and traditions of the MTFAS and that I shall abide by the Constitution, By-Laws and Regulations of the Squad at the present and as amended from time to time.

Signature of applicant:	Date:

Montville Township First Aid Squad

REQUEST FOR CRIMINAL HISTORY RECORD INFORMATION FOR A NONCRIMINAL JUSTICE PURPOSE

(TYPE OR PRINT ALL INFORMATION)

COMPLETE NAME AND ADDRESS OF REQUESTING AGENCY

MONTVILLE TOWNSHIP FIRST AID SQUAD

137 CHANGEBRIDGE ROAD

MONTVILLE, NJ 07045

ASSIGNED IDENTIFIER (ORI Number)

N/A

REQUESTING AGENCY USE ONLY

N/A

NAME (Including Maiden Name)

SBI NUMBER (If known)

_____

(Last Name) (Middle Name) (First Name)

ADDRESS

FBI NUMBER (If known)

_____

(Number) (Street) (City) (State)

DOB	SEX	RACE	SOCIAL SECURITY NUMBER
_____ (Month) / (Day) / (Year)			

Phone Number:

I certify that I am authorized to receive Criminal History Record Information pursuant to a Federal or State Statute, Rule or Regulation, Executive Order, Administrative Code Provision, Local Ordinance, or Resolution, I understand that the Criminal History Record Information received shall not be disseminated to person unauthorized to receive the information.

MONTVILLE TOWNSHIP FIRST AID SQUAD

(Enter the appropriate Statute, Rule or Regulation, Executive Order, Administrative Code, Local Ordinance, or Resolution.)

_____ _____ Type or Print Name of

Authorized Person Making Request Signature of Authorized Person Making Request

AUTHORIZATION BY SUBJECT OF REQUEST AND PRIVACY ACT NOTIFICATION

Supervisor, State Bureau of Identification:

I hereby authorize the release of any Criminal History Record Information maintained by your agency, meeting dissemination criteria, for the above stated Criminal Justice Purpose to _____ (Insert name of agency you authorize to receive this information)

Pursuant to the Privacy Act of 1974 (P.L. 93-579), I realize that disclosure of my social security number is voluntary. I also realize my social security number will be used by the State Bureau of Identification for the purpose of facilitating the security check authorized by the above referenced authority information released as a result of this authorization, including the furnishing of my social security number, shall be used only for the express purpose of processing the above indicated application.

X_____

Signature of Applicant Date

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Montville Township First Aid Squad Physical Form

Date	Applicant Member Name D. O. B

Member Health Questionnaire:

Do you have any of the following conditions: (check all that apply)

High Blood Pressure		Phlebitis Stroke	
Allergies		Diabetes Asthma	
Seizure Disorders		Tuberculosis Migraines	
Surgery (Major)		Alcoholism G.I. Problems	
Coronary Disorder		Drug Abuse Back Injury	
Hepatitis		COPD Other:	

Explanation: Any conditions that would affect, inhibit, or prevent you from working in an ambulance

_____

_____

____ I do NOT suffer from any of the above conditions or any other condition that would prevent me from working on an ambulance.

Immunizations: M ___ M ___ R ___ Hepatitis B ___ Other:_____

Tuberculosis Test? (Y/N)_____ if so, Date:_____ Result:_____

Are you presently taking any medications that would inhibit/prevent your ability to perform the duties of a riding squad member?(Y/N)_____ if so, please list your medications and explain:

_____

_____

Are you allergic to any medications, foods, insect bites (bee stings), or materials (latex)? No ___ Yes ___, please explain _____ Do you have any of the following impairments? Hearing ___ Vision ___ Speech ___ Do you have any lifting restrictions? (Y/N) _____ Back problems? (Y/N) _____ Vitals: Blood Pressure: _____ HR: _____ Respiratory Rate: _____

I have examined the above-named person and found no condition that appears to prevent them from performing the duties of an ambulance squad member, including lifting, driving, kneeling, and high stress. They are medically cleared to receive the Hepatitis B vaccine if they desire.

Additional recommendations/comments: _____

_____

_____

Please attach a copy of vaccination/immunization records as well as a medical abstract.

Certifying Physician Name:

_____

Certifying Physician Signature: Date: _____

_____