

New Milford Community Ambulance Corp.

Application For Membership

New Milford Community Ambulance Corp.

General Requirements for Membership

- Applicant must either live or work in the Town of New Milford.
- Applicant must be 18 years of age or older. (Persons under 18 and already certified as a Connecticut EMT will be given special consideration by the Board.)
- Applicant must be in good health and able to perform the duties of an EMT/MRT (*see page 3.*)
- Applicant must presently have (or obtain within 12 months) CT certification as an EMT or MRT.
- As a member you must be on duty a **minimum** of twenty four (24) hours each month.
- As a member you must attend a minimum of six (6) monthly business meetings.
- As a member you must attend a minimum of five (5) monthly training sessions.

Read the application carefully, sign where appropriate and note that page 3 must be completed by your physician and page 4 must be notarized.

***Mail* the completed application to the below address.**

All questions should be addressed to the Screening Committee:

Carol Kuczko 355-8597
Bob Dumas 354-6208
Larry Tripp 354-8720

New Milford Community Ambulance Corp.

Name: _____ DOB: _____

All other names by which you have been known:

Address: _____

City: _____ State: _____ Zip: _____ e-mail address: _____

Primary Phone No.: _____ Secondary Phone No.: _____

How long have you lived or worked in New Milford? _____

Place of employment: _____

Position: _____ Phone: No.: _____

Length of time employed by current employer? ____ If less than two years, name and address of previous employer: _____

Are you now or have you ever been certified as an: EMT EMR CPR No certification

If certified what is/was your State Registration Number: _____

If other medical training/certification list type, certif. no.'s and dates: _____

Have you been trained in patients' rights, privacy and/or HIPAA? (Y?N) ____

When would you be available for calls? Days? Nights? Weekends?

Do you have any medical limitations? (Y/N) ____ If "yes," please explain: _____

Motor vehicle Operators license number : _____

Have you had any motor vehicle accidents or convictions over the past 3 years? (Y / N) ____ If "yes," please explain: _____

Have you every had your operator's license suspended or revoked? (Y/N) ____ If "yes," when, in what state and for how long? _____ Describe the circumstances that resulted in the suspension / revocation: _____

References:

If you were previously (or are now) a member of a volunteer emergency service (including fire) please provide the name of an officer under whom you have served.

Name: _____ Position: _____

Organization: _____ Phone no.: _____

If you are **not** now (or have **never** been) a member of an emergency service please provide the name of a *current* work supervisor whom we may contact.

Name: _____ Position: _____

Company: _____ Phone no.: _____

Please note that references will be checked and that a satisfactory police background check and medical approval from your doctor are essential to our selection process. (See pages 3 & 4).

I here authorize the New Milford Community Ambulance Corporation permission to verify the above statements.

Signature of applicant: _____ Date: _____

P. O. Box 102 * New Milford, CT 06776 * Tel. (860) 355-1769 * Fax (860) 210-0852

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New Milford Community Ambulance Corp.

Name: _____

Applicant Questions

Question No. 1: Why do you want to join? (including what you want to get from the experience)

Question No. 2: What do you think you would bring to this organization?

Question No. 3: What does your family think of you exploring joining the NMA?

Question No. 4: What is your understanding of what we require of our members?

Signature of applicant: _____ Date: _____

New Milford Community Ambulance Corp.

Health Examination Form

The intent is to ensure that you can perform the duties of an EMT MRT safely and successfully.

It is expected that your physician will perform a complete physical examination before certifying the below.

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

***** The below is to be completed by your physician *****

Physician's Recommendations

I have performed a complete physical examination of the above individual and am not aware of any contraindications toward his/her participation as an EMT / MRT.	
I understand that functioning as an EMT / MRT will regularly require this individual to lift 75-80 lbs.	
I understand that functioning as an EMT / MRT will regularly require this individual to be in contact with ill and/or injured persons.	
I recommend the applicant not participate as an EMT / MRT.	
Physician's signature:	Date:
Physician's name (print):	Phone:
Address:	City: State & Zip:

New Milford Community Ambulance Corp.

Authorization for the Release of Personal Information

The intent of this authorization is to give your consent for full and complete disclosure of records, background reports, disciplinary matters, records of arrests and/or convictions, including criminal and/or civil.

I _____

All other names by which you have been known

do hereby authorize a review of and full disclosure of all records or any part thereof, concerning myself, by and to any duly authorized agent of the New Milford Police Department, The Connecticut State Police, whether said records are of a public, private or confidential nature.

A photocopy of this release will be valid as an original hereof, even though the said copy does not contain an original signature.

I hereby additionally authorize the release of any of the above information/records to the New Milford Community Ambulance Corporation.

Signature

Date of Birth

Social Security Number

Address: _____

City: _____ State: _____ Zip: _____

Subscribed and sworn or affirmed before me this _____ day of _____, 20____.

(Signature) Notary Public

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