



New Milford Community Ambulance Corporation

20 Youngs Field Road * P.O. Box 102 * New Milford, CT 06776

Tel. (860)355-1769 * Fax (860)210-0852

<http://www.newmilfordambulancect.org>

Application

For

Membership



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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 the age of 18 and already certified as a Connecticut EMT will be given special consideration by the Board of Directors.
- 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) Connecticut certification as an EMT or MRT.
- As a member you must be on duty a ***minimum*** of twelve (12) 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:

New Milford Community Ambulance

ATTN: Applications

P.O. Box 102

New Milford, CT 06776

All questions should be addressed to the Screening Committee:

Carol Kuczko (860)355-8597

Bob Dumas (860)354-6208

Pam Fox (860)355-0656



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General Information

Name: _____ Date of Birth: _____

All other names by which you have been known: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

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

Place of employment: _____

Position: _____ Phone Number: (____) _____

Length of time employed by current employer: _____

If less than two years, name and address of previous employer: _____

Previous medical training and dates: _____

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

If "yes," when and where: _____

When would you be available for calls? Days Nights Weekends

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

Drivers License Number: _____ State Issued: _____

Have you had any motor vehicle accidents or convictions over the past 3 years? (Y/N) _____

If "yes" please explain: _____

Have you ever had your drivers license suspended or revoked? (Y/N) _____ If "yes" when, in what state, and for how long? _____

Describe the circumstances for 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 Number: (____) _____

Name: _____ Position: _____

Organization: _____ Phone Number: (____) _____

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: _____



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Applicant Questions

Applicant Name: _____

Question #1: Why do you want to join? (Including what you want to get from the experience)

Question #2: What do you think you would bring to this organization?

Question #3: What does your family think of you joining New Milford Community Ambulance?

Question #4: What is your understanding of what we require of our members?

Signature of Applicant: _____ Date: _____



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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: _____ Date of Birth: _____

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: _____ State: _____ Zip: _____



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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 _____

(List 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 any of the above information/records to the New Milford Community Ambulance Corporation.

Signature of Applicant

Date of Birth

Social Security Number

Address: _____

City: _____ State: _____ Zip: _____

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

(Signature) Notary Public