



CHAL-BRIT REGIONAL EMS

201 PARK AVE.
P.O. BOX 506
CHALFONT, PA 18914-0506
PHONE: 215-822-1308
FAX 215-822-1841

VOLUNTEER MEMBERSHIP APPLICATION

PERSONAL INFORMATION

DATE OF APPLICATION: _____

NAME		SOCIAL SECURITY NO.		
PRESENT ADDRESS	APT	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	APT	CITY	STATE	ZIP CODE
HOME PHONE ()	CELL PHONE ()	PAGER ()	NEXTEL ID / OTHER	
E-MAIL ADDRESS		ARE YOU ATLEAST 18 YEARS OF AGE?		<input type="checkbox"/> YES <input type="checkbox"/> NO

RECOMMENDED BY: (SQUAD MEMBER MAKING RECOMMENDATION FOR MEMBERSHIP ACCEPTANCE)

NAME:	POSITION:
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VOLUNTEER POSITION DESIRED

<input type="checkbox"/> OBSERVER <input type="checkbox"/> EMT <input type="checkbox"/> PARAMEDIC <input type="checkbox"/> OTHER: _____			DATE YOU CAN START
ARE YOU EMPLOYED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF APPLYING AS A PARAMEDIC, DO YOU PRESENTLY HAVE BUCKS COUNTY COMMAND?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
EVER APPLIED TO THIS ORGANIZATION BEFORE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	WHEN?	

EDUCATION HISTORY

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK OR SPECIAL TRAINING/SKILLS:	
U.S. MILITARY OR NAVAL SERVICE	RANK

DO YOU HAVE A VALID DRIVER'S LICENSE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	STATE ISSUED	DRIVER'S LICENSE #
CLASS OF LICENSE	DATE ISSUED	EXPIRATION DATE			
HAVE YOU EVER HAD ANY MOVING VIOLATIONS, OR HAD YOUR LICENSE REVOKED OR SUSPENDED?					<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, EXPLAIN:					
LIST ALL MOVING VIOLATIONS (CONVICTIONS) AND ACCIDENTS IN THE LAST FIVE YEARS:					
HAVE YOU EVER BEEN CONVICTED, PLED GUILTY, OR NO CONTEST TO A FELONY OR MISDEMEANOR, INCLUDING DUI/DWI OR SIMILAR OFFENSE?					<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, EXPLAIN:					

A conviction will not necessarily disqualify you from membership.

REFERENCES GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN ATLEAST ONE YEAR

NAME	ADDRESS	BUSINESS	YEARS KNOWN

PRESENT EMPLOYER (IF APPLICABLE)

EMPLOYMENT START DATE	NAME & ADDRESS OF EMPLOYER	POSITION	SUPERVISOR
JOB DUTIES:			MAY WE CONTACT? Y N

OTHER MEMBERSHIPS (IF APPLICABLE)

NAME & ADDRESS OF ORGANIZATION	YEARS WITH ORGANIZATION	POSITION	SUPERVISOR
DUTIES IF ANY:			MAY WE CONTACT? Y N
DUTIES IF ANY:			MAY WE CONTACT? Y N
DUTIES IF ANY:			MAY WE CONTACT? Y N

HAVE YOU EVER BEEN (CIRCLE ANSWER):

DISCIPLINED OR FIRED FOR INSUBORDINATION?	YES	NO
DISCIPLINED OR FIRED FOR VIOLATION OF SAFETY RULES?	YES	NO
DISCIPLINED OR FIRED FOR ASSAULT OR FIGHTING?	YES	NO
DISCIPLINED OR FIRED FOR HARASSMENT?	YES	NO
DISCIPLINED OR FIRED FOR PATIENT ABUSE?	YES	NO
DISCIPLINED OR FIRED FOR ALCOHOL OR DRUG RELATED ACTIVITY AT WORK?	YES	NO

IF YOU ANSWERED YES TO ANY QUESTION ABOVE, PLEASE EXPLAIN: _____

ANSWERS OF YES FOR ANY OF THE ABOVE QUESTIONS WILL NOT NECESSARILY DISQUALIFY YOU FROM MEMBERSHIP.

EMS CERTIFICATIONS

CERTIFICATION	CERT. NUMBER	DATE OF COMPLETION	EXPIRATION DATE	INSTITUTION
(CIRCLE IF APPLICABLE) FR / EMT / EMT-P / PHRN				
CPR (Healthcare Provider)	N/A			
EVOC				

ATTACH COPIES OF ALL APPLICABLE CERTIFICATIONS CARDS (DOH CERT, CPR, ACLS, PALS/APLS, PHTLS, OTHER)

**** PLEASE ENCLOSE \$10 APPLICATION FEE FOR BACKGROUND CHECK!! ****

AUTHORIZATION

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

If offered a position and at any time thereafter, I consent to medical examinations as may be required to determine my fitness to perform the job duties.

I consent to allow any doctor, hospital, or testing laboratory to conduct any medical test or examination as may be required by the company as a condition of my membership, and I hereby give my consent to the release of all information which the company deems necessary to determine my ability to perform job duties now or in the future.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

I also hereby permit the Department of Transportation, State Police, or any other government agency to perform and furnish a copy of my driver's record, criminal background check, child abuse clearance check, or credit history to Chalfont EMS, Inc."

SIGNATURE _____ DATE _____

REMARKS (OFFICIAL USE ONLY)

INTERVIEWED BY: _____ DATE: _____

DATE OF MEMBERSHIP APPROVAL: _____

ELECTED SQUAD OFFICER SIGNATURE: _____ POSITION: _____