

Hopatcong Ambulance Service, Inc.

Membership Application

Please Print All Information and return to:
P.O. Box 334 Hopatcong, NJ 07843

Date: \_\_\_\_\_

Full Name (Print) \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How long at present address? \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of children: \_\_\_\_\_

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1. If under two years list previous address: \_\_\_\_\_

2. Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor: \_\_\_\_\_

If employed with above employer less one year list previous employer:

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Supervisor: \_\_\_\_\_

May we contact above Employers? YES: \_\_\_\_\_ NO: \_\_\_\_\_

3. 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: \_\_\_\_\_

: \_\_\_\_\_

4. Driver's License Number: \_\_\_\_\_

5. Total points currently against driver's license: \_\_\_\_\_

Has your license ever been suspended? YES: \_\_\_\_\_ NO: \_\_\_\_\_ Why? \_\_\_\_\_

Have you ever been convicted of a DWI? YES: \_\_\_\_\_ NO: \_\_\_\_\_

6. List all other organizations to which you belong, the length of time of membership and positions held: \_\_\_\_\_

7. Have you ever been a member of a First Aid squad? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Name & Address: \_\_\_\_\_

Date of membership: \_\_\_\_\_ Phone: \_\_\_\_\_

Position held: \_\_\_\_\_

8. List any First Aid or CPR certification you presently carry and when they expire:

CPR: \_\_\_\_\_ First Aid: \_\_\_\_\_ EMT: \_\_\_\_\_ EMT-D: \_\_\_\_\_

EMT-P: \_\_\_\_\_ LPN: \_\_\_\_\_ RN: \_\_\_\_\_ MD: \_\_\_\_\_

Or other: \_\_\_\_\_ If applying for DRIVER position check here: \_\_\_\_\_

9. List any other medical training you may have: \_\_\_\_\_

10. Do you have any physical or learning disabilities: YES: \_\_\_\_\_ NO: \_\_\_\_\_

If yes, explain: \_\_\_\_\_

**References**

(Name, relationship, phone number)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Hours of availability**

Daytime: \_\_\_\_\_  
: \_\_\_\_\_  
: \_\_\_\_\_

Nighttime: \_\_\_\_\_  
: \_\_\_\_\_  
: \_\_\_\_\_

Your acceptance as a member of this squad will be determined (in part) by your hours of availability and the need for members for those hours.

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

Hopatcong Ambulance Squad Inc.

Membership Application

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.

\_\_\_\_\_  
*Applicants Signature*

Date: \_\_\_\_\_

**Physical Test Record**

(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.*

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 or has had previously:

**GENERAL**

Allergies \_\_\_\_\_ Convulsions \_\_\_\_\_ Dizziness \_\_\_\_\_ Fainting \_\_\_\_\_  
Nervousness/Depression \_\_\_\_\_ Neuralgia \_\_\_\_\_ Numbness \_\_\_\_\_  
Tremors \_\_\_\_\_

**MUSCLE & JOINTS**

Arthritis \_\_\_\_\_ Bursitis \_\_\_\_\_ Foot Trouble \_\_\_\_\_ Hernia \_\_\_\_\_  
Lower Back Pain \_\_\_\_\_ Lumbago \_\_\_\_\_ Neck Pain or Stiffness \_\_\_\_\_

**PAIN OR NUMBNESS IN:**

Arms \_\_\_\_\_ Elbows \_\_\_\_\_ Hands \_\_\_\_\_ Legs \_\_\_\_\_ Knees \_\_\_\_\_  
Spinal Curvature \_\_\_\_\_

**GASTROINTESTINAL**

Colitis \_\_\_\_\_ Liver Disease \_\_\_\_\_

**EYES, EARS, NOSE & THROAT**

Asthma \_\_\_\_\_ Deafness \_\_\_\_\_ Failing Vision \_\_\_\_\_

**CARDIOVASCULAR**

High Blood Pressure \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_

**RESPIRATORY**

Chest Pain \_\_\_\_\_ Difficulty Breathing \_\_\_\_\_ Wheezing \_\_\_\_\_

Check the following conditions if they apply to the patient:

Alcoholism \_\_\_\_\_ Anemia \_\_\_\_\_ Arthritis \_\_\_\_\_ Chorea \_\_\_\_\_  
 Diabetes \_\_\_\_\_ Emphysema \_\_\_\_\_ Epilepsy \_\_\_\_\_ Heart Disease \_\_\_\_\_  
 Multiple Sclerosis \_\_\_\_\_ Polio \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_  
 Scarlet Fever \_\_\_\_\_ Stroke \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Ulcers \_\_\_\_\_

Any Communicable Diseases – (Please List) \_\_\_\_\_

Is the Applicant presently on any medications? If so please list, and explain for what reason?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has Applicant ever suffered from a hernia? \_\_\_\_\_ Present Condition of the hernia:

\_\_\_\_\_

Has Applicant ever suffered from back problems? \_\_\_\_\_ Present Condition of back problems: \_\_\_\_\_

Remarks/Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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I HEREBY CERTIFY THAT THIS APPLICANT IS PHYSICALLY FIT \_\_\_\_\_ OR UNFIT \_\_\_\_\_ TO PERFORM THE DUTIES REQUIRED HEREIN AS A HOPATCONG AMBULANCE SERVICE MEMBER.

\_\_\_\_\_  
 PRINTED NAME OF PHYSICIAN                      DATE                      SIGNATURE OF PHYSICIAN

**INVESTIGATING COMMITTEE REPORT**

Date Application Received: \_\_\_\_\_

Number of Application: \_\_\_\_\_

Date Acted on by Committee: \_\_\_\_\_

Date Approved by Committee: \_\_\_\_\_

Date of Probation: \_\_\_\_\_

Date Accepted as an Active Member: \_\_\_\_\_

Comments of Committee: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signatures of Committee Members: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_