Springwater Wayland EMS

APPLICATION FOR MEMBERSHIP

PO Box 625
Wayland, New York 14572

Date: _____

_____
(Last Name) (First Name) (M.I.)

_____
(Street Address) (Apt./Suite No.)

_____
(City, Town, Village) (State) (Zip Code)

Telephone Number: (____) ____-_____ (____)____-_____ (____) ____-_____
(Home) (Cell) (Work)
Cell Provider:_____

Email Address: _____

How long have you resided at the above address? Years: _____ Months: _____

Are you 18 years of age or older? Yes No If No, state your age: _____

Is additional information about a change in your name or your use of assumed name or nickname necessary to enable a check on your eligibility for membership?
Yes No If "Yes", explain: _____

Driving Information

Driver's License Number: _____ State: _____

Class: _____ Restrictions: _____ Expiration: _____

Any moving violations (Please describe): _____

_____

Number of years driving: _____

Have you taken: Defensive Driving Yes No
CEVO Yes No
EVOC Yes No

Any other driver training class? _____

Prior Medical Training

Are you an EMT? Yes No If yes, Certification Number: _____
Are you a CFR? Yes No

Do you have a current CPR card? Yes No Expiration: _____

Do you have any other medical certifications or credentials?

_____

_____

Previous emergency services experience: (include only fire, rescue, police and emergency medical services agencies).
Name of Agency: _____
Address: _____
Contact Person: _____ Telephone: (____) ____-_____
(If more space is needed, please attach additional sheet)

Prior Military: Yes No If yes: Which branch? _____

Dates of Service: _____

Availability

Please indicate your availability to participate in ambulance activities and respond to calls
Week Days: Days: _____ Evenings: _____ Nights: _____
Weekends: Days: _____ Evenings: _____ Nights: _____

Are you interested in becoming an EMT or a Driver? EMT Driver

References

Please list two personal references who have known you for at least 1 year.

Name: _____ Telephone Number: (____) _____-_____
Address: _____

Name: _____ Telephone Number: (____) _____-_____
Address: _____

Background Check

Social Security Number: _____

Date of Birth: _____

Are you currently employed? Yes No

If "Yes", may we contact your employer as a reference? Yes No

Name of Company: _____

Address: _____

Telephone: (____) _____-_____

Please provide a copy of your Driver's License and EMT card.

Have you ever been convicted or plead guilty to a felony, insurance fraud, arson, or a reduction of one of these offenses? Yes No

If "Yes", please attach an additional sheet and give complete details.

WITHIN THE FREEDOM OF INFORMATION LAW, ALL INFORMATION CONTAINED/OR OBTAINED HEREIN WILL REMAIN CONFIDENTIAL AND WILL BE USED ONLY FOR INTERNAL MEMBERSHIP PROCESSING.

IN WITNESS WHEREOF, THIS APPLICATON HAS BEEN SUBSCRIBED THIS DAY OF _____, 20____ BY THE UNDERSIGNED APPLICANT WHO AFFIRMS THAT THE STATEMENTS MADE HEREIN ARE TRUE UNDER THE PENALITIES OF PERJURY.

APPLICANT SIGNATURE: _____

DATE: _____

WITNESSED BY: _____

DATE: _____

PRIVACY NOTIFICATION

Section 94 of the Public Officers Law (Personal Privacy Protection Law) requires that you be notified of the following facts when information which will be maintained in a record system is collected from you.

The authority to request and confirm personal information about you is found in Article 6 of the Executive Law.

The information obtained will: be used to determine your qualifications for the positon for which you are applying; be released to the ambulance chief and your potential supervisors; and be maintained in your personnel file (if you become a ambulance company member) or in our resume file for six months (if you are not a ambulance company member). Failure to provide the information or authorization will result in your application not being considered for membership.

The information will be maintained by Springwater Wayland Emergency Medical Services, Inc. Secretary at PO Box 625, Wayland NY 14572.

Springwater Wayland Emergency Medical Services, Inc.
PO Box 625
Wayland, New York 14572

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

In order to confirm the information I supplied on my application for membership with the Springwater Wayland Emergency Medical Services, Inc. I authorize all licensing agencies, educational institutions, law enforcement agencies, present and former employers, and the military services to disclose their relevant records about me to the Springwater Wayland Emergency Medical Services, Inc. whether the information be of public, private or confidential nature; and I release them from any liability and responsibility from doing so.

The authorization, in original copy form, shall be vailed for this and any future information, reports or updates that may be requested.

I understand that this form will accompany requests for official documents and confirmations of my credentials.

_____	_____	
Applicant Name (Please Print)	Application's Signature	Date

Witnessed by:

_____	_____	
Name and Title (Please Print)	Witness Signature	Date