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Name: _____ (Please Print) Monitor #: _____ (Leave blank)



MEMBERSHIP APPLICATION



Havre de Grace Ambulance Corps, Inc.

1601 Level Road
P. O. Box 465
Havre de Grace, MD 21078
"Arundel Station"

Phone: 410-939-6658
Fax: 410-939-6665

WELCOME PROSPECTIVE MEMBER

Thank you for your interest in our organization. As a public service agency that operates on a totally volunteer basis, we are constantly in need of new and enthusiastic personnel. All applications will be given equal consideration regardless of race, sex, age, color, national origin, marital status, religion, or handicap. Answers to questions on this form will not be used to discriminate against any applicant.

Becoming an emergency medical care provider is demanding as well as a rewarding experience. You become part of an elite group of individuals who assist members of your own community on a daily basis, without the benefit of a paycheck. The work is hard, and the calls for help do not always come at the most convenient times, but the satisfaction of serving your fellow citizens rides high. We need well-trained personnel to answer calls 24 hours a day, and we hope that you will become one of our best.

To aid you through transition as a probationary member of the Havre de Grace Ambulance Corps, Inc., we have designed this application to assist you and possibly answer some of your questions. Upon obtaining an application from one of our members, you will see it has two parts:

1. The Application for Membership
2. The Outline to assist the new member (what you are now reading)

Fill out the application and return it to one of our members as soon as possible. (There is a \$1.00 (one dollar) application fee that must accompany this application).

After turning in your application, it will be forwarded to the company investigating committee. This committee will review your application, run a background check, and then you will be contacted to meet with the committee for the interview. After the interview, the committee will bring your application before the members at the next regularly scheduled company meeting, with a recommendation, either to accept or reject your application, at which time the company will then vote to accept or reject your application. If you are voted in, you will be contacted that night and invited to join in the remainder of the meeting.

Once your application is accepted by the membership, you will serve a 1-year probationary period. Applicants are required to sign for, read and abide by the By-Laws of the Havre de Grace Ambulance Corps, Inc. A copy of these By-Laws will be given to you during your pre-basic course, which is a mandatory training course conducted by the Training Committee, during the first 3 months of the probationary period. Also, each new member of the Corps will receive or decline to receive the Hepatitis-B vaccine. Cost of the vaccine will be paid by the Corps. Any probationary member, prior to their election as a regular member, who loses their membership by either act or omission, shall be required to reimburse the Corps for the cost of vaccinations. Probationary members not elected to regular membership, after completion of the probationary period, will not be required to reimburse the Corps for the cost of the vaccinations.

It is the responsibility of all members to make every attempt to attend clean-ups, social functions, training, and spend time at the station to get to know your fellow volunteers. Upon finishing your pre-basic training, you will be cleared by the Training Committee to ride the ambulances. You are fully insured by our company as soon as your application is accepted by the membership, so you are covered as a full member from the time that you join.

A probationary member must start an EMT class within the first year and complete and pass the class. This class is formal training to function as an emergency medical care provider. During your training and membership, all personal protective equipment will be issued to you at no cost to the member. This gear includes: coat and pants, helmet with eye protection and protective gloves. Pagers will be given out to members at the discretion of the officers according to established policy.

Well, if all this seems like a lot, it is. Being an Emergency Medical Care Provider is not an easy job. Even in the volunteer EMS service, there is a lot of time and training that must be given to do the job right. We work hard to serve the community and to better ourselves as members of it. There are no promises here. The work that we will ask you to do is hard, dirty and many times, thankless. You will be cold, wet, afraid, and respected by those who work beside you. We appreciate the offer of your time to serve the community. The volunteer EMS service requires special people to do a special job. Your only paycheck will be the satisfaction you derive from the service you give to your community and the friendship you obtain from the close-knit family of EMT's and Paramedics you are about to become a part of.

IF YOU ARE WILLING TO INVEST IN US, THEN WE ARE WILLING TO INVEST IN YOU.

***THE HAVRE DE GRACE AMBULANCE CORPS, INC.
WELCOMES YOU!***

REMINDERS:

- The Company meets on the 1st and 3rd Mondays each month at 7:00 pm, with the exception of January (1st Monday of the month); February (1st Monday of the month); and September (2nd Monday of the month)
- Be sure your application is signed and completely filled out (with your dollar attached)
- Any general questions regarding your membership should be directed to any member

DETACH THIS MEMBERSHIP OUTLINE AND HOLD IT FOR FUTURE REFERENCE



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Membership Application

Monitor # _____
(Leave Blank)

Name: _____, _____, _____
(Last) (First) (Middle)

Street Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____

Date of birth: ____/____/____ Current Age: _____ Social Security#: ____/____/____

Sex: (Male) (Female) Driver's License #: _____ State _____

Home Phone# () _____ Work Phone # () _____

Spouse's Name _____ Spouse's Work Phone # () _____

Emergency Contact (Name & Phone #) _____

Email address: _____

Medical History _____

Medications _____

Allergies _____

Restrictions, if any: _____

Have you ever been convicted of a crime? Yes () No ()

Have you ever had any healthcare certification or license withheld, suspended, revoked, denied, or have you surrendered, or allowed a license or certificate to expire or lapse as the result of an investigation or disciplinary action? Yes () No ().

If yes, please explain: _____

Have you ever been convicted of, or pled guilty to, or pled nolo contendere to or received probation before judgment for any crime other than a minor traffic violation? Yes () No ()

If yes, please explain: _____

Interested in: **(check one)** Regular Membership: () Associate Membership: ()

Have you ever been a member of this Company or any other Fire or EMS Company? If so please fill out this section in detail.

Company Name _____ Phone Number () _____

Address _____

Years of Service: _____ Offices/Positions Held: _____

Date Left _____ Reason _____

List any previous Training in Fire or EMS and certifications as appropriate: _____

MOTIVATION:

Explain why you want to be a member of our organization: _____

PRESENT EMPLOYER

Company Name _____ Phone () _____

Address _____
(Street) (City) (State) (Zip)

Position _____ Date Hired _____

Supervisor _____

May we contact your employer: Yes _____ No _____

If no, please explain: _____

If less than five (5) years with present employer, give past employer information

Company Name _____ Phone () _____

Address _____
(Street) (City) (State) (Zip)

Position _____ Date Hired _____

Supervisor _____

Date and reason for leaving _____

List three (3) Business, Professional or Personal references (required):

(1) Name _____ Phone () _____

Address _____
(Street) (City) (State) (Zip)

How long known? _____ Type of relationship _____



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The following information is optional and is to be filled out at the discretion of the applicant. Any information contained herein cannot be used to determine membership and will remain confidential.

Height: _____ Weight: _____ Eye Color: _____

Hair Color: _____ Blood Type: _____ Corrected Vision: _____

Do you have any of the following conditions of which we should be aware:

Allergies: (medications, etc) Yes _____ No _____

Hearing Impairments Yes _____ No _____

Heart Related Problems Yes _____ No _____

Alcohol or Substance Abuse Yes _____ No _____

Mental or Emotional Problems Yes _____ No _____

Physical Impairments Yes _____ No _____

If you answered yes to any of the above, please explain:



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RECORD RELEASE FORM

(APPLICANT'S SIGNATURE REQUIRED)

I, _____ do hereby grant permission to the Investigation Committee of the Havre de Grace Ambulance Corps, Inc., the Board of Directors of the Havre de Grace Ambulance Corps, Inc., and any person, party, agency, or member of the said above committees to investigate any criminal history or record I have or may have. I also grant permission to the above stated committees to obtain disclosure of any criminal, medical, psychiatric, or driving record I have or may have, whether said record(s) may be public or private in nature. I am aware that a background investigation can lead to the rejection of my application for membership and I absolve any member of the Havre de Grace Ambulance Corps, Inc., from any civil action on my part which may result from said rejection.

(Applicant Signature/Date)
(Required)

Witness Signature/Date
(Required)

Witness's Address

PARENTAL CONSENT FOR MINORS

I hereby give my son/daughter permission to join the Havre de Grace Ambulance Corps. I understand that they will need to abide by the bylaws and regulations as governed in the Standard Operating Guidelines manual.

Name of Student _____ Date ____/____/____

Parent/Guardian Signature _____

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DO NOT WRITE IN THIS SECTION REPORT FROM INVESTIGATING COMMITTEE

Recommend for 1-year probation Yes _____ No _____

Committee Chairman _____ Date _____

ATTENDEES

Investigating Committee Member _____ Date _____

Investigating Committee Member _____ Date _____

Investigating Committee Member _____ Date _____

Investigating Committee Member _____ Date _____

Investigating Committee Member _____ Date _____

Comments: _____

PROBATIONARY PERIOD REPORT FORM

Start of probationary period – Date: _____ Completed Date: _____

Total Man-hours: _____ Total Responses: _____

Total Company Meetings: _____ Total Company Meetings Attended: _____

Completion Date of EMT: _____ (Attach copy of EMT Certification Card)

List any Training other than required training attended: _____

Comments: _____

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