

Do Not Copy

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 \$5.00 (five 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 1<sup>st</sup> and 3<sup>rd</sup> Mondays each month at 7:00 pm, with the exception of January (1<sup>st</sup> Monday of the month); February (1<sup>st</sup> Monday of the month); and September (2<sup>nd</sup> Monday of the month)
- Besure your application is signed and completely filled out(with your Five dollars 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: ( )

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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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