



MEMBERSHIP APPLICATION OPERATIONS GROUP

P.O. Box 911, Hadlyme, CT 06439

DATE _____

Applicant Information (Print)

Name: _____
Last First MI

Address: _____

Phone: (home) _____
(cell) _____

Cell phone provider: _____
(Email: _____)

Emergency Contact Person (Print)

Name: _____

Address: _____

Phone: (home) _____
(cell) _____

Type of Cell Phone Check One: Android _____ or iPhone _____

CURRENT EMPLOYMENT: _____

AVAILABILITY: DAYTIME HOURS: _____ EVENING HOURS: _____

WEEKEND HOURS: _____

EDUCATIONAL BACKGROUND:

High School or Equivalent: _____ Year of Graduation: _____

College: _____ Year of Graduation: _____

Technical School or Training: _____ Dates Attended and Certification: _____

CURRENT FIRST AID/EMS TRAINING & CERTIFICATION: FILL IN ANY THAT APPLY.

1.	<input type="checkbox"/> Date _____	CPR	
2.	<input type="checkbox"/> Date _____	FIRST AID (STANDARD)	
3.	<input type="checkbox"/> Date _____	FIRST AID (ADVANCED)	
4.	<input type="checkbox"/> Expiration Date _____	EMR CERTIF #: _____	
5.	<input type="checkbox"/> Expiration Date _____	EMT CERTIF #: _____	
6.	<input type="checkbox"/> Date _____	OTHER:	

REFERENCES

Please obtain signatures of two members of the community who know you personally and are willing to recommend you for membership in the Lyme Ambulance Association.

Name _____

Address _____

Phone _____

Signature _____

Name _____

Address _____

Phone _____

Signature _____

MEDICAL INFORMATION:

1. Do you have or have you ever had an illness or injury which would limit your ability to perform the duties required in an emergency ambulance service?
☐ NO ☐ YES Details: _____
2. Do you have, or have you ever had a chronic illness or condition requiring regular medication?
☐ NO ☐ YES Details: _____
3. You are required to a) have a complete Hepatitis Vaccine Series or b) sign the Declination of Hepatitis B Vaccine Form. Have you had a complete Hepatitis B Vaccine series?
☐ NO ☐ YES Date: _____ Doctor: _____
If NO, then you must receive a complete vaccination series within 6 months or sign the Declination Form.
If YES, please provide the medical documentation with the Membership Application.
If YES, and you don't have the medical documentation or the vaccination series was completed 20+ years ago, then a titer is required with medical documentation or you must sign a Declination Form.
4. A TB test is required for membership with medical documentation of a negative result, please provide medical documentation with the Membership Application or Medical Clearance Letter.

PLEASE READ CAREFULLY

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

In consideration for employment or promotion within Lyme Ambulance Association or affiliates on our behalf, Employers Reference Source may make inquiries, including but not limited to, your consumer credit history, education, professional licensing, criminal history, driving history, your personal character, abilities, work habits, mode of living, residency, immigration status, general reputation, performance, experience and other qualities pertinent to your qualifications for employment, including reasons for termination from your past employment.

In compliance with the Americans With Disabilities Act, only after a contingent offer of employment is offered, will your workers' compensation history be investigated for the purpose of making certain that you are not hired for a position or assigned to a job function that could aggravate a previous injury.

In compliance with the Fair Credit Reporting Act, you are entitled to be informed if an offer of employment is withheld because of information obtained from Employers Reference Source and, in that event, we will provide a copy of the report we receive and the FTC notice, "A Summary of Your Rights Under the Fair Credit Reporting Act."

Please complete and sign the form which follows, authorizing, without reservation, any party, including but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by Employers Reference Source to furnish any or all of the above listed information. Your authorization releases Employers Reference

Source from any and all liability for damages arising from the investigation and disclosure of the requested information. Further, it releases and discharges all liability from all companies, agencies, officials, officers, employees and other persons, who, in good faith, provide to Employers Reference Source the above-mentioned information as requested, in order to successfully complete a background investigation.

For your records, a copy of this completed notice that a consumer report may be obtained for employment purposes will be provided if requested. Please retain it for your records.

Your signature below allows a photocopy or fax copy of this authorization to be as valid as the original.

Print Full Name: _____

Have you used any other name? Y N If yes, what name did you use? _____

Social Security #: _____ *Date of Birth: _____

Driver's License #: _____ State Issued: _____

Please provide the date(s) of any motor vehicle convictions

Have you lived or held a driver's license in another state in the past 10 years? Yes____ No____

Have you ever been convicted of a felony? Yes____ No____

If yes, please provide details on an attached sheet. Pages Attached Yes____ No____ # of pages____

Applicant Signature: _____ **Date:** _____

*Date of birth is being requested only for purposes of identification in obtaining accurate retrieval of records and it will not be used for discriminatory purposes.

GENERAL INFORMATION

Each applicant will be interviewed by the Recruiting/Retention Officer and/or the Chief of Service.

LAA business meetings and in-house training sessions are held on the second Monday of each month, usually 6:00-9:00 pm, at Hamburg Station.

Applicants MUST attend one (1) Business meeting and one (1) Training to be eligible to be voted in as a member.

Applicant Signature: I agree to abide by the By-Laws, policies and protocols of Lyme Ambulance Association.

Signature _____ *Date* _____

To submit this application, contact Ariana Eaton at 860-510-2815, or Steve Olstein at 860-941-9603, or mail it to Lyme Ambulance Association, P.O. Box 911, Hadlyme, CT 06439.

DO NOT FILL IN SECTION BELOW

Office Use Only

APPLICATION STATUS

INVESTIGATING COMMITTEE REPORT

INTERVIEWED BY _____ DATE _____ RECOMMENDED: ☐ YES ☐ NO

COMMENTS (or attach interview report): _____

DEPARTMENT ACTION

- 1) PRESENTATION AT MEETING: Date _____ ☐ BACKGROUND, Driving: Date _____
- 2) TRAINING ATTENDANCE: Date _____ ☐ BACKGROUND, Criminal: Date _____
- 4) ELECTED TO MEMBERSHIP: Date _____ ☐ Mentor _____

Approved _____
Chief of Service Date