Application #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Township of Middletown**

**Emergency Medical Services**

**900 Leonardville Road, Leonardo, NJ 07737**

**APPLICATION FOR MEMBERSHIP**

Please check off the Squad closest to your residence

\_\_\_\_\_\_ Middletown First Aid & Rescue Squad

Monmouth Pky. & Cruse Pl., Middletown

Mailing Address: P.O. Box 128, Middletown, NJ 07748

732-787-0099

\_\_\_\_\_\_ Fairview First Aid Squad

Kanes Lane, Middletown

Mailing Address: 17 Kanes Lane, Middletown, NJ 07748

732-275-1633

\_\_\_\_\_\_ Port Monmouth First Aid Squad

Wilson Ave. & Pulsch St., Port Monmouth

Mailing Address: P.O. Box 113, Pt Monmouth, NJ 07758

732-787-9566

\_\_\_\_\_\_ Leonardo First Aid & Rescue Squad

Viola Ave., Leonardo

Mailing Address: P.O. Box 222, Leonardo, NJ 07737

732-291-8650

\_\_\_\_\_\_ Lincroft First Aid & Rescue Squad

Hurleys Lane, Lincroft

Mailing Address: P.O. Box 282, Lincroft, NJ 07738

732-842-0640

**TOWNSHIP OF MIDDLETOWN**

**EMERGENCY MEDICAL SERVICES**

**900 Leonardville Road, Leonardo, NJ 07737**

Chris Lombardi

President

Floyd Goldstein

Chief

Dear Applicant,

Thank you for your interest in joining the Township of Middletown Emergency Medical Services. As you know, we are a totally, 100% all volunteer service. New members are always in need, so please fill out your application as soon as possible and return it to the squad you wish your application to be submitted to.

Membership responsibilities vary from squad to squad, but can easily be summed up as: Fund Raising, meetings, drills and most importantly, answering the call for help.

If you have the time and the willingness to learn life-saving skills and help others in need, then you are the future of the Middletown Emergency Medical Services. Join our team today. As soon as your application is received, someone will notify you for an interview.

Again, thank you for showing an interest in the Township of Middletown Emergency Medical Services. We look forward to working with you in the near future.

Sincerely,

Chris Lombardi

President

Township of Middletown

Emergency Medical Services

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_/\_\_\_/\_\_\_

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

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

(if different than above)

Years at present Address:\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Hours:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Supervisors Name/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drivers Lic. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date:\_\_\_/\_\_\_/\_\_\_

State:\_\_\_\_\_\_\_\_

Current Certification(check all that apply)

\_\_\_EMT exp.\_\_\_/\_\_\_ \_\_\_CPR exp.\_\_\_/\_\_\_ \_\_\_Hazmat \_\_\_Def. Driving

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been convicted of a crime other than a traffic violation, if so please state county, and when:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any conditions that would keep you from performing your duties? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby authorize the Township of Middletown Emergency Medical Services to examine my background with Law Enforcement Officials. I understand that any findings in said check will be kept confidential and, if applicable, will result in the rejection of my application. I understand that I must obtain a physical from a bonafide physician stating that I am able to complete all requirements put upon me by the Township of Middletown Emergency Medical Services and that all information obtained be kept confidential.

If accepted as part of the Township of Middletown Emergency Medical Services for membership, I promise to abide by the Constitution and the By-Laws of the organization and perform my duties to the best of my ability.

I attest that all information above is true to be the best of my knowledge and that any misrepresentation of information may be grounds for my immediate dismissal from the organization.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_

**----------FOR OFFICIAL USE ONLY----------**

Date interviewed:\_\_\_/\_\_\_/\_\_\_ Approved for membership: **Y** *OR* **N**

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date accepted:\_\_\_/\_\_\_/\_\_\_ Membership Status:\_\_\_/\_\_\_/\_\_\_ Badge #:\_\_\_\_\_\_

Date of Active Status:\_\_\_/\_\_\_/\_\_\_ Date of Life Status:\_\_\_/\_\_\_/\_\_\_

Date of Resignation:\_\_\_/\_\_\_/\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TOWNSHIP OF MIDDLETOWN**

**EMERGENCY MEDICAL SERVICES**

**PHYSICIAN’S REPORT**

**Date:\_\_\_/\_\_\_/\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_**

**Weight:\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_ B/P:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_\_**

**Blood Type:\_\_\_\_\_\_\_\_\_\_\_\_ Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organ Donor: Y *or* N**

# Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there anything that would limit or restrict your patient to any duties pertaining to EMS?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:**

## Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The above named patient is cleared to participate/perform in the duties of your organization with the following restrictions:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of M.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**