MEMBERSHIP APPLICATION

PO BOX 111 EDEN, NEW YORK 14057 (716) 992-4460

NAME: _____

ADDRESS: _____

_____

PHONE (HOME): _____

PHONE (WORK): _____

EMAIL: _____

NYS DRIVERS LICENSE #: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

(NAME) _____

(PHONE) _____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

MAY WE CONTACT: ☐ YES ☐ NO

HAVE YOU APPLIED TO THIS ORGANIZATION BEFORE? ☐ YES ☐ NO

DO YOU HAVE ANY FIRST AID EXPERIENCE? ☐ YES ☐ NO

IF SO, PLEASE LIST: _____

FIRST AID: ☐ CPR ☐ AHA ☐ ARC EXP DATE: _____

FIRST RESPONDER: CERT#: _____ EXP DATE: _____

EMT-B: CERT#: _____ EXP DATE: _____

EMT-I: CERT#: _____ EXP DATE: _____

EMT-CC: CERT#: _____ EXP DATE: _____

EMT-P: CERT#: _____ EXP DATE: _____

OTHER: _____

MEMBERSHIP REQUIREMENTS:

1. Must be at least eighteen (18) years of age.
2. Must attend 75% of EMS training meetings.
3. Must have six (6) hours of duty each week.

I affirm that my answers to the questions in this application and any other information which I have furnished in connection with my application for membership to the Eden Emergency and Rescue Squad is true and correct. I also affirm that I have not knowingly withheld any facts or circumstances which would, if disclosed, affect my application unfavorably. I agree that the Eden Emergency and Rescue Squad or its agent may exercise the right, now or in the future, to verify the information in this application I have provided them. I understand that any misrepresentation will be caused for immediate suspension.

SIGNATURE OF APPLICANT: _____ DATE ____ / ____ / ____

MEMBERSHIP COMMITTEE USE ONLY: DATE APPLICATION RECEIVED ____ / ____ / ____ DATE APPLICANT INTERVIEWED ____ / ____ / ____

DATE APPLICANT ACCEPTED TO MEMBERSHIP ____ / ____ / ____