Community Ambulance Company

P.O. Box 450
Sayville, NY 11782
631-567-2586

Associate Membership Application

PERSONAL DATA: **Date:** _____

Name: _____ **DOB:** _____/_____/_____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell #:** _____

Email Address: _____ **Cell Provider:** _____

Social Security #: _____ - _____ - _____ **Driver's License #:** _____

Have you ever been a Member of another EMS/Fire/Police/Rescue or other similar organization? _____ **If yes, where?** _____

What is/was your position/duties? _____

Status of Membership: **Active** **Terminated** **Resigned**

TRAINING: ** **Attach copy of certificate, if applicable.**

Special Skills or Training: _____

Understand that this is a 24hr volunteer service. Based upon this, there will be times that you will be required to respond to calls at night, weekends and/or holidays. Are there any objections to responding at such times? _____

Community Ambulance operates on 6 hour shifts during the day (6am – 6pm) or 12 hour shifts during the night (6pm – 6am). It is required that members ride a weekly shift. Weekends cannot be guaranteed. We ask our members to have some flexibility in their schedules to move around if needed. Are there any objections to this? _____ **If yes, please explain** _____

_____

Have you ever been refused or denied membership, suspended or expelled from any organization? If yes, please explain: _____

Have you ever applied for membership to this company before? _____

Do you have a reliable source of transportation? _____

Explain briefly why you wish to be a member of Community Ambulance Company:

_____

_____

Signature: _____ **Date:** _____

Community Ambulance Company, Inc.

Over 65 Years Serving
Bayport – Bohemia – Oakdale – Sayville – West Sayville

DISCLOSURE AND RELEASE

In connection with my application for employment with Community Ambulance Company,

I give authorization to Community Ambulance Company to request and receive from any employer, company, governmental agency, or source, and utilize, any and all information pertaining to my prior and current employment(s) and my NYS Emergency Medical certification. For the duration of my employment with it I authorize Community Ambulance Company to seek, receive and update any such information, and I understand that as a condition of employment that it is my obligation to remain credentialed with Suffolk County Department of Health, Division of EMS. A copy of this signed authorization will be forwarded to Suffolk County Department of Health, Division of EMS.

I understand that consumer reports, which may contain public record information, may be requested and obtained. These reports may include information related to my previous driving record including court actions, citations, license suspensions and revocations.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right to obtain information as to the name, address and phone number of any agency providing such information and further, may request of that agency, upon proper identification, the nature and substance of all information in its files on me at the time of my request, including all sources of information as well as the recipients of any reports on me which that agency has previously furnished within the two (2) year period preceding my request.

This authorization shall remain on file and shall serve as ongoing authorization for the organization named above to procure Suffolk County Department of Health, Division of EMS and New York State Motor Vehicle Department at any time during my employment.

_____ (Signature)	_____ (Date)
_____ (Print Name)	_____
_____ (Driver's License Number)	_____ (State)
_____ (Certification #)	_____ (Expiration Date)

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Please attach a copy of valid driver's license.

I hereby authorize the Suffolk County Police Department to perform a complete criminal convictions records check and record of any pending criminal charges, and authorize the release of this information directly to the above-named agency.

Name: _____

Address: _____

_____

Date of Birth: _____

Social Security # _____ - _____ - _____

Signature: _____

Date: _____

STATE OF NEW YORK)
)SS:
COUNTY OF SUFFOLK)

On the _____day of _____ before me personally came and appeared _____ to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that (s)he executed the same.

_____
Notary Public

Post Office Box 450 – Sayville, New York 11782-0450
Phone Number 631-567-2586 Fax Number 631-567-6593