

**Washington Ambulance Association, Inc.**

# **Application For Membership**



**P.O. Box 294 - 109 Bee Brook Road - Washington Depot, CT 06794 - (860) 868-7913**

**Washington Ambulance Association, Inc.**  
**General Requirements for Membership**

- Applicant must either live or work in or near the town of Washington, CT
- Applicant must be 18 years of age or older. *(persons under 18 and already certified as a Connecticut EMT or EMR will receive consideration by the Officers)*
- Applicant must be in good health and able to perform the duties of an EMT/EMR. *(please see "Health Examination Form" attached)*
- Members must meet all of the requirements stated in the Washington Ambulance Association, Inc. bylaws.

**Please read the application carefully, sign where appropriate, and note that a "Health Examination Form" must be completed by Concentra, and the "Authorization for Release of Personal Information Form" must be notarized.**

**Please mail or hand-deliver the completed application to the Officers.**

Any questions should be addressed to an Officer

- Chief of Operations: Adam Woodruff  
phone: (860) 868-7913 or (860) 671-1352  
email: chief@washingtonambulance.org
- Assistant Chief: Heidi Johnson  
phone: (860) 868-7913 or (860) 488-4009  
email: assistantchief@washingtonambulance.org
- Captain: Bill Hickey (860) 868-7913 or (814) 574-7891  
email: captain@washingtonambulance.org

# Washington Ambulance Association, Inc.

## Applicant Questionnaire

Applicant Name: \_\_\_\_\_

1.) Why do you want to join and what do you hope to gain from the experience?

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2.) What do you think you will bring to this Association?

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3.) What do you understand the requirements of membership to be?

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\_\_\_\_\_  
applicant signature

\_\_\_\_\_  
today's date

# Washington Ambulance Association, Inc.

## Applicant Information

(page 1 of 2)

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

All other names by which you have been known:

\_\_\_\_\_

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

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

How long have you lived or worked in Washington? \_\_\_\_\_

Current Place of Employment: \_\_\_\_\_

Job Title/Description: \_\_\_\_\_ Hire Date: \_\_\_\_\_

EMS Certification held (*circle all that apply*) EMT-P EMT-I EMT-B EMR CPR NO CERT.

If certified, your state certification number: \_\_\_\_\_

Have you been trained in patients' rights, privacy, and HIPAA? (*circle one*) YES NO

When will you likely be available to respond to emergency calls? (*circle all that apply*)

DAYS NIGHTS WEEKENDS RARELY

Do you have any medical or physical limitations? (*circle one*) YES NO

If "yes", please explain: \_\_\_\_\_

# Washington Ambulance Association, Inc.

## Applicant Information

(page 2 of 2)

Driver's License Issuing State & number: \_\_\_\_\_ Expiration: \_\_\_\_\_

Have you had any accidents or convictions over the past 3 years? (circle one) YES NO

If "yes", please explain: \_\_\_\_\_

Have you ever had your driver's license suspended or revoked? (circle one) YES NO

If "yes", please explain: \_\_\_\_\_

### References:

If you are now, or were previously, a member of a volunteer emergency service (EMS or Fire), please provide the name of an Officer under whom you have served.

Organization: \_\_\_\_\_

Your Position/Duties: \_\_\_\_\_

Your Supervising Officer's Name: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

If you are not now, or have ever been, a member of an emergency service (EMS or Fire), please provide the name of your current work supervisor whom we may contact.

Company Name: \_\_\_\_\_

Your Supervisor/Employer's Name: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Please note that references will be checked and that a satisfactory Police background check and medical approval from a Physician are essential to our selection process.

**I hereby authorize Washington Ambulance Association, Inc. permission to verify the above statements.**

\_\_\_\_\_  
applicant signature

\_\_\_\_\_  
today's date

# Washington Ambulance Association, Inc.

## Applicant Health Examination Form

The intent is to ensure applicant can perform the duties of an EMT/EMR safely and successfully.

It is expected that applicant will get an appropriate health examination approved by Washington Ambulance Association, Inc. and performed by Concentra.

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

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

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*\*\*\*\* This section below is to be completed by an approved Physician of Concentra\*\*\*\*\***

### Concentra's Recommendations

- I have performed a complete physical examination of the above individual and am aware of any/all contraindications toward his/her participation in Emergency Medical Services as an EMT or EMR.
- I understand that functioning as an EMT/EMR will regularly require this individual to lift up to 75-80 lbs.
- I understand that functioning as an EMT/EMR will regularly require this individual to be in contact with ill and/or injured persons.

Physician Name (PRINTED) \_\_\_\_\_

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

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
today's date

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## Authorization for Release of Personal Information

**\*\*\* TO BE COMPLETED IN THE COMPANY OF A NOTARY PUBLIC \*\*\***

The intent of this authorization is to give consent for full and complete disclosure of records, background reports, disciplinary matters, records of arrests and/or convictions, including criminal and/or civil.

I, \_\_\_\_\_

PRINTED applicant's name (including all other names by which I have been known)

Do hereby authorize a review of, and full disclosure of, all records or any part thereof, concerning myself, by and to any duly authorized agent of the Washington Police Department and Connecticut State Police, whether said records are of a public, private, or confidential nature.

*A photocopy of this release will be valid as an original hereof,  
even though said copy does not contain an original signature*

I hereby additionally authorize the release of any of the above information/records to the Washington Ambulance Association, Inc.

\_\_\_\_\_  
applicant signature

\_\_\_\_\_  
today's date

Applicant's D.O.B. \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscribed and sworn or affirmed before me on this \_\_\_\_\_ Day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public signature