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

*** Leonardo First Aid & Rescue Squad requires an application fee, call for details.

TOWNSHIP OF MIDDLETOWN
EMERGENCY MEDICAL SERVICES
900 Leonardville Road, Leonardo, NJ 07737

Dena Hansen
President

Chris Lombardi
Vice 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,

Dena Hansen
President
Township of Middletown
Emergency Medical Services

Date:___/___/___

Name:_____ D.O.B.:___/___/___ S.S.#:_____

Address:_____

_____

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:_____

_____

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

_____

_____

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

_____

_____

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:_____

_____

Date accepted:___/___/___ Membership Status:___/___/___ Badge #:_____

Date of Active Status:___/___/___ Date of Life Status:___/___/___

Date of Resignation:___/___/___

Comments:_____

_____

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:

_____

_____

Signature of M.D._____ Date:___/___/___

Address:_____ Phone:_____