EAST MORICHES COMMUNITY AMBULANCE

AMBULANCE COMMITTEE OF THE MORICHES, INC.
Business (631) 878-4230 Fax: (631) 878-8337

275 MONTAUK HWY
P.O. BOX 295
EAST MORICHES, NEW YORK
11940

APPLICATION FOR MEMBERSHIP

NAME: _____

ADDRESS: _____

HOME PHONE #: _____

CELL PHONE #: _____

EMAIL ADDRESS: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

DRIVERS LICENSE #: _____

VIOLATIONS IN THE LAST 3 YEARS: _____

_____

MEDICAL BACKGROUND (CPR, EMT, LPN, RN, ETC...): _____

IF LICENSED INCLUDE # AND EXPIRATION DATE: _____

ORGANIZATIONS TO WHICH YOU CURRENTLY or HAVE BELONGED:

_____

_____

EMPLOYER: _____

ADDRESS: _____

PHONE#: _____ OCCUPATION: _____

PAST MEDICAL HISTORY: _____

_____

BLOOD TYPE: _____ HEPATITIS VACCINE? YES/NO

ALLERGIES: _____

WHAT TIME OF DAY ARE YOU GENERALLY AVAILABLE? DAYS___ NIGHTS___

CALL NIGHTS AVAILABLE (11PM to 5AM): _____

IS THERE ANY INFORMATION THAT YOU THINK THIS ORGANIZATION SHOULD BE MADE AWARE OF IN REFERENCE TO YOUR APPLICATION TO BECOME A MEMBER OF THIS CORPS? _____

_____

HAVE YOU EVER BEEN ARRESTED (WHETHER OR NOT CONVICTED)?: YES/NO

IF YES, STATE REASON AND OUTCOME: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR?: YES/NO

IF YES, STATE CHARGE CONVICTED AND OUTCOME: _____

IT SHOULD BE UNDERSTOOD THAT BY SUBMITTING THIS APPLICATION FOR MEMBERSHIP IN THE AMBULANCE COMMITTEE OF THE MORICHES, INC. (EAST MORICHES COMMUNITY AMBULANCE), YOUR FIRST SIX (6) MONTHS IN THE CORPS SHALL BE ON A PROBATIONARY PERIOD. DURING THE PROBATIONARY PERIOD, A MEMBER SHALL COMPLETE AT THE MINIMUM, A CPR COURSE, AND SHALL BE IN-SERVICED ON THE AMBULANCE AND REVIEWED BY THE TRAINING OFFICER AND PRESIDENT TO HIS/HER SATISFACTION. ALL MEMBERSHIP REQUIREMENTS, AS SET FORTH IN THE BYLAWS AND CONSTITUTION OF OUR ORGANIZATION NEED TO BE MET DURING THIS PROBATIONARY PERIOD IN ORDER FOR YOU TO BECOME AN ACTIVE MEMBER. IT SHOULD ALSO BE UNDERSTOOD THAT THE EAST MORICHES COMMUNITY AMBULANCE IS A VOLUNTEER, NON-PROFIT ORGANIZATION AND THAT NO MONETARY COMPENSATION WILL BE GIVEN TO YOU OR, ACCEPTED BY YOU, FOR YOUR SERVICES. YOU WILL ABIDE BY ALL NATIONAL, STATE, LOCAL, AND INSTITUTIONAL LAWS PERTAINING TO THIS ORGANIZATION.

East Coast Applicant Screening

Phone: 631-225-1578 (800-240-6889)
Fax: 631-225-1580

AUTHORIZATION TO CONDUCT BACKGROUND INQUIRIES

The undersigned applicant hereby authorizes **East Moriches Community Ambulance & East Coast Applicant Screening** as its agent to conduct a background inquiry on him/herself. The undersigned applicant understands that these inquiries shall include informational data regarding his/her credit, criminal, motor vehicle, litigation, education, military and any other pertinent information as it may apply for the prospective job position.

The undersigned applicant authorizes **East Moriches Community Ambulance & East Coast Applicant Screening** as its agent to contact any previous employer or personal reference to obtain information relating to this application for employment.

Further, **if applicable**, the applicant authorizes **East Moriches Community Ambulance & East Coast Applicant Screening** to take a sample of my urine to be tested for evidence of illegal drug abuse.

The applicant hereby releases **East Moriches Community Ambulance & East Coast Applicant Screening** as its agent from any and all liability relating to such inquiries.

Please Provide the prospective Job Position:_____

SIGNATURE:_____ DATE:_____

PRINT NAME:_____ Other Names Used:_____

ADDRESS:_____

TOWN:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SS#:_____

STATE OF DRIVER'S LICENSE_____LICENSE#_____

[FOR OFFICIAL USE ONLY-DO NOT WRITE BELOW]

☑ Criminal –State: NY	☐ Employment Verification (#____)
☐ Credit	☐ Education Verification
☑ DMV License	☐ Behavioral Survey
☑ Social Security Trace	☑ Sex Offender Database
☑ Drug Test	☑ Patriot Search

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ SIGNED: _____

NOTIFICATION IN CASE OF EMERGENCY: _____

TELEPHONE #: _____

PLEASE ATTACH A COPY OF YOUR DRIVERS LICENSE AND MEDICAL CERTIFICATIONS AND RETURN THIS APPLICATION TO THE MEMBERSHIP COMMITTEE MAILBOX LOCATED BY THE BACK DOOR OF THE AMBULANCE OR TO THE ABOVE ADDRESS.

_____ _____

Signature Date

For filing purposes only:

DATE INTERVIEWED: _____
MEMBERS PRESSENT: _____
_____

MEMBERSHIP COMMITTEE APPROVED: YES / NO

DATE PRESENTED TO THE BOARD: _____
BOARD APPROVED: YES / NO

DATE PRESENTED TO THE MEMBERSHIP: _____
VOTE: YES_____ NO_____

APPROVED / DENIED