EAST MORICHES COMMUNITY AMBULANCE

AMBULANCE COMMITTEE OF THE MORICHES, INC
Mailing Address: P.O. Box 295 East Moriches, NY 11940
Physical Address: 275 Montauk Hwy East Moriches, NY 11940
Phone: (631) 878-4230 | Fax: (631) 878-8337
Email: 54730@eastmorichesambulance.org

Dear Applicant,

Thank you for taking an interest in joining the East Moriches Community Ambulance. Please fill out the attached application and return it to the Membership Committee.

At the end of this application, please attach a copy of your current driver's license and any medical certifications you may have.

If you have have questions, please call us at (631) 878-4230 or email 54731@eastmorichesambulance.org

Sincerely,
Membership Committee
East Moriches Community Ambulance

Application for Membership

Volunteer Profile

Last Name_____First _____ M.I._____
Date of Birth _____
Address_____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____ Cell Provider _____
Email Address _____

Date of Birth: _____
Social Security _____-_____-_____
Driver's License #: _____
(Attach a copy of your driver's license at the end of this application)

Violations in the Last 3 Years: _____

_____

Volunteer Profile (cont)

Is there any information that you think this organization should be made aware of about your application to become a member of this Crops?

_____

_____

Have you ever been arrested (Whether convicted or not)? 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: _____

Have you ever been a member of the East Moriches Ambulance Junior Program? YES / NO. If yes when? _____

Medical Background (CPR, EMT, LPN, RN, Etc): _____
(Attach a copy of your certifications to the end of this application)

Have you ever been or currently apart of any other emergency service organization (including youth squads, juniors, etc)? YES / NO. If Yes:
_____
_____
_____

Employment

Occupation: _____
Name of Employer: _____
Address: _____
Work Phone: (_____) _____ - _____

Military Service

Branch of Service _____ Date of Entry _____
Date of Discharge _____ Type of Discharge _____
The Explanation of Discharge if anything other than Honorable._____
_____
_____

Present Military Status._____

Medical History

Past Medical History:_____

_____

Blood Type: _____ Hepatitis Vaccine? YES? NO

Allergies: _____

What time of the day are you generally available? Days___ Nights___

Nights available (9PM to 5AM): _____

The above information is true and correct to the best of my knowledge.

Date: _____ Signature: _____

__Please attach a copy of your driver's license and medical certifications__ and return this application to the membership committee mailbox located by the side door of the ambulance to the above address

_____ _____

Signature Date

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 application 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 hereby 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 application 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_____ LICNESE#_____

[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