



JAMAICA ESTATES HOLLISWOOD SOUTH BAYSIDE VOLUNTEER AMBULANCE CORPS.

207-07 Union Turnpike
P.O. Box 640181 Oakland Gardens Station
Bayside, NY 11364-0181
718-464-0592

APPLICATION FOR MEMBERSHIP

<input type="checkbox"/> Full Membership	Date: _____
<input type="checkbox"/> Associate Membership (Non-Ambulance Activities)	
<input type="checkbox"/> Youth Squad Membership (Ages 15-17 yrs.)	

PLEASE PRINT CLEARLY OR TYPE ALL INFORMATION

Last Name: _____ First Name: _____ M.I.: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work Telephone: _____
Pager Telephone: _____ Cell Telephone: _____
Internet Email Address: _____
Gender: Male Female Date of Birth: _____

EMPLOYMENT INFORMATION:	<input type="checkbox"/> Not Currently Employed
Name of Last / Current Employer: _____	
Address of Employment: _____	
Supervisor: _____ Supv. Phone: _____	
Position: _____ Length of time at Employer: _____	

EDUCATION INFORMATION:	<input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate / Professional
Name of School Now / Last attended: _____	
Highest Grad Completed: _____ Year Grad: _____	

MEDICAL TRAINING INFORMATION:	<input type="checkbox"/> No Medical Training
<u>List all current Licenses and attach a photocopy of all certifications:</u>	
<input type="checkbox"/> CPR <input type="checkbox"/> CFR <input type="checkbox"/> EMT-B <input type="checkbox"/> EMT-D <input type="checkbox"/> EMT-I <input type="checkbox"/> EMT-A <input type="checkbox"/> EMT-P <input type="checkbox"/> RN / LPN <input type="checkbox"/> MD	
<input type="checkbox"/> Non NY State Certification <input type="checkbox"/> NREMT <input type="checkbox"/> Other (explain) _____	
1) Training Organization Name: _____	
Certification Number: _____	Expire Date: _____
2) Training Organization Name: _____	
Certification Number: _____	Expire Date: _____

CURRENT / PRIOR EMS ORGANIZATION MEMBERSHIP INFORMATION
Name of Organization: _____
Start Date of Membership: _____ Reason for Leaving: _____

Applicant Name: _____ Date: _____

PLEASE ANSWER ALL QUESTIONS BELOW: (Please explain any "YES" answers)		YES	NO
1)	Why do you wish to join our volunteer ambulance corps.?		
2)	Are you involved in any other groups / organizations? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
3)	Are you fluent in any languages besides English?	<input type="checkbox"/>	<input type="checkbox"/>
4)	Are you REQUIRED to perform community service? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
5)	Have you ever been convicted of a Misdemeanor or Felony Crime as an adult? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
6)	Has this or any other ambulance or rescue organization ever denied you membership?	<input type="checkbox"/>	<input type="checkbox"/>
7)	Have you ever been disciplined by any agency or organization while serving as a health care provider? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
8)	Has your license to drive a motor vehicle ever been suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>

INTENTIONALLY BLANK

PLEASE LIST AT LEAST TWO NON-FAMILY PERSONAL REFERENCES	
Name of Reference #1:	Name of Reference #2:
Address:	Address:
Telephone Number:	Telephone Number:
Relationship to Applicant:	Relationship to Applicant:
Length of time Known by Reference:	Length of time Known by Reference:

I affirm that the above application contains no misstatements or omissions and is completely true and correct. If my application is accepted, I agree to abide by all the rules and regulations of the Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. ("JEVAC") at all times. I further authorize JEVAC to verify the information I have provided in this application. False statements made here on this application may result my suspension and / or revocation of membership.

By accepting membership to JEVAC, I agree to serve during designated hours and make myself available at such times. In addition, I am expected to offer my time whenever possible when called upon to relieve a fellow member. I may be called upon in an emergency even though it may not be my duty time.

I understand that my membership application will be voted upon by the general membership, and I understand that my application is conditional on the following requirements: (a) If applying for ambulance or dispatch duties, I have been examined by a medical physician who has determined me to be fit for those duties and (b) having completed a ninety (90) to one hundred eighty (180) day probationary period. During that period, squad officers and the training and membership committees will have monitored and evaluated my performance.

I hereby accept and agree to all the terms of this application.

Name: _____ Signature: _____ Date: _____



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MOTOR VEHICLE DRIVER'S LICENSE INFORMATION

DISCLOSURE AND RELEASE AGREEMENT

In connection with my duties as a driver with the "Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps" ("JEVAC"), I understand that a "consumer report" which may contain public record information, will be requested from the State Department of Motor Vehicles. This report will include information related to my driving record, including court actions, citations, license suspensions, and revocations.

I AUTHORIZE, WITHOUT RESERVATION, THE RELEASE OF THE ABOVE MENTIONED INFORMATION.

I have the right to obtain information as to the name, address, and telephone 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 said applicant, at the time of my request. To include all sources of information as well as the recipients of any reports on said applicant, which the 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 Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps., its insurance company, and / or insurance broker to procure Motor Vehicle reports at any time during my membership of JEVAC.

Print Name as shown on driver license

Social Security Number

Date of Birth

Signature

Date

Driver License Number

State of Issue

Expire Date

All of the information contained in this application will be kept strictly confidential, and will not be disclosed, discussed or disseminated to third parties outside our organization without your written approval.



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PHYSICIAN MEDICAL CLEARANCE FORM

Applicant Name: _____ Date: _____

Dear Physician,

The person whose name appears above has applied for membership to the Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. Some physical and mental requirements of rendering emergency medical care on an ambulance include working in inclement weather, control of emotions while working under stressful conditions and strength of lifting and carrying patients and medical equipment.

After consideration of these requirements and the applicant's medical history, mental and physical condition, please answer the following questions:

- 1) In your opinion, the applicant is fit to perform and cleared to serve as:
Radio / Telephone Dispatcher Yes No
Ambulance Driver Yes No
Technician / Attendant Yes No
- 2) Does the applicant have any medical, physical or mental conditions that would cause restrictions from performing any and all activities related to the above checked positions? Yes No
(Examples of such conditions include, but are not limited to: Vision or Hearing problems, Heart disease, Lung disease, Epilepsy / Seizures, Hypertension, Fainting spells, Drug or Alcohol abuse)

If Yes, Please Explain: _____

Physician Signature Date

Physician Name: _____

Address: _____

Telephone Number: _____

Thank you for your time,
Sincerely,
The Membership Committee

Jamaica Estates Holliswood So. Bayside Volunteer Ambulance Corps

Policy on Confidentiality and Dissemination of Patient Information and Staff Member Verification

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. We prohibit the release of any patient information to anyone outside our organization (exclusive of health professionals directly involved in the care of the patient in question) and discussions of Protected Health Information (PHI) of our patients within the organization should be limited. Acceptable uses of PHI within the organization include but are not limited to peer review, internal audits, quality assurance and billing. I understand that Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of our patients. I understand that it is necessary, in the rendering of our services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such confidential information is regarded as strictly confidential and protected by Federal and state laws that prohibit its unauthorized use or disclosure for treatment, payment and health care operations.

I agree that I will comply with all of the confidentiality policies and procedures set in place by Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. in its manual of "Standard Operating Procedures" during my association with Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. If I, at any time, knowingly or inadvertently breach the patient confidentiality policies and procedures, I agree to notify the Captain or Privacy Officer of Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. immediately. In addition, I understand that a breach of patient confidentiality may result in my suspension or termination of my association with Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. Upon termination of my association for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession.

I have read and understand all privacy policies and procedures that have been provided to me by Jamaica Estates Holliswood So. Bayside Volunteer Ambulance Corps. I agree to all the conditions of my association set forth in this agreement. This is not a contract of association or employment and does not alter the nature of the relationship between Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. and myself.

Staff Member

Signature: _____ *Date:* _____

Printed

Name: _____

HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to me.

HEPATITIS B VACCINE CONSENT

I consent to administration of the hepatitis B vaccine. I have been informed of the method of administration, the risks, complications and expected benefits of the vaccine.

Signature of Employee

Date

Print Employee's Name

HEPATITIS B VACCINE DECLINATION

I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature of Employee

Date

Print Employee's Name