



**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  
YOUTH CORPS (Ages 15-17 years old)**

**PLEASE PRINT CLEARLY ALL INFORMATION**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Internet Email Address: \_\_\_\_\_

Gender:  Male  Female Date of Birth: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

**EDUCATION INFORMATION:**

Name of School Now attending: \_\_\_\_\_

Address of School: \_\_\_\_\_

Current Grade: \_\_\_\_\_

**MEDICAL TRAINING INFORMATION:**

**No Medical Training**

List all current Licenses and attach a photocopy of all certifications:

CPR  CFR  EMT-B

Non NY State Certification

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: \_\_\_\_\_

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.

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

<b>PLEASE ANSWER ALL QUESTIONS BELOW: (Please explain any "YES" answers)</b>		<b>YES</b>	<b>NO</b>
1)	Why do you wish to join our volunteer ambulance corps?		
2)	Are you fluent in any languages besides English?	<input type="checkbox"/>	<input type="checkbox"/>
3)	Has any other ambulance or rescue organization ever denied you membership?	<input type="checkbox"/>	<input type="checkbox"/>
4)	Have you ever been admitted to a hospital? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
5)	Have you ever been admitted to a psychiatric institution? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
6)	Do you suffer from any <input type="checkbox"/> physical or <input type="checkbox"/> mental impairment? (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>

<b>PLEASE LIST AT LEAST TWO NON- FAMILY PERSONAL REFERENCES</b>	
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:

<b>GUARDIAN / EMERGENCY CONTACT INFORMATION:</b>
Name of Parent / Guardian: _____
Telephone: (Home) _____ (Office) _____ (Cell) _____
<b>PARENT / GUARDIAN RELEASE / PERMISSION TO JOIN:</b> I hereby authorize my child (or the above mentioned applicant, for whom I have guardianship over) to join and participate in all activities of the Youth Squad. I understand that there may be some physical and mental requirements for rendering emergency medical care on an ambulance including working outside in inclement weather, control of emotions while working under stressful conditions and may involve carrying of medical equipment. I understand that at all times, there will be adult supervision of all activities. The parent /guardian may decide to limit activities at any time.
Signature of Parent / Guardian: _____ Date: _____

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 and conduct myself in accord with all the rules and regulations of the Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps. ("JEVAC"). I further authorize JEVAC to verify the information I have provided in this application. False statements made on this application may result my suspension and / or revocation of membership.

By accepting membership to JEVAC, I agree to serve during my 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 understand that I may be called upon to assist in an emergency.

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

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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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 Youth Squad. Some physical and mental requirements of rendering emergency medical care on an ambulance include working outside in inclement weather, control of emotions while working under stressful conditions and may involve carrying of 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ambulance Attendant          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- 2) Does the applicant have any medical, physical or mental conditions that you are aware of 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, cardiac issues, 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 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 South 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 and does not alter the nature of the relationship between Jamaica Estates Holliswood South Bayside Volunteer Ambulance Corps and myself.

### **Applicant:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

### **Applicant's Parent / Guardian:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_