RUMSON FIRST AID SQUAD
(MEMBERSHIP APPLICATION)

MEMBERSHIP TYPE (CHOOSE ONE)

ADULT_____ CADET_____

NAME: _____ D.O.B. _____

HOME ADDRESS: _____ HOME TEL: _____

OCCUPATION: _____ WORK TEL: _____

BUSINESS ADDRESS: _____

EMAIL ADRESS: _____ CELL TEL: _____

NJ DRIVER'S LICENSE? _____ LICENSE #_____

Have you ever had your license suspended or revoked in any state? _____ Have you ever plead guilty to (besides parking) a motor vehicle traffic violation/offense? _____ If yes, please explain _____

Have you ever been a member of a first aid squad? _____ If yes, where and when? _____

Reason you left previous squad? _____

Do you have a Healthcare Provider CPR Card? _____ Exp. Date_____(attach copy)

Do you have a National and/or New Jersey E.M.T Card? _____ EMT Number_____ Exp. Date_____
                                                                                    (attach copy)

Are you attending an E.M.T Class? _____ If yes, where? _____

Do you have any previous/current medical conditions that could affect your ability to provide basic medical care
_____
If yes, please explain_____

Have you ever been arrested? _____ If Yes – What was the charge(s) and disposition of the case? (Attach relevant records) _____

_____

_____   _____   _____
Applicant Signature   Parent/Guardian Signature   Date of Application
                                              (For Cadet Applications)
_____

STATE OF NEW JERSEY, COUNTY OF MONMOUTH

SS: BEING DULY SWORN, DOTH DEPOSE AND SAYS THAT THE ABOVE
STATEMENTS ARE TRUE TO BEST OF HIS/HER KNOWLEDGE AND BELIEF

SWORN TO BEFORE ME THIS_____DAY OF_____, _____

_____   Notary Seal
Notary Signature

PHYSICAL REPORT
(TO BE FILLED OUT BY A PHYSICIAN AND NOTARIZED)

Age: _____   Weight_____   Height_____   Blood Pressure_____

OVERALL HEALTH CONDITION OF_____: (PLEASE CIRCLE ONE- Poor/Fair/Good/Excellent)
                                                     Name

Heart Abnormalities or History: Y/N   Vision: 20/20 or corrected to _____   Hearing Difficulty: Y/N_____

Does the individual suffer from any medical condition that would prevent him/her from operating a motor vehicle, including an emergency motor vehicle, or any medical condition that would prevent the individual from providing basic medical care? _____ If Yes Please state condition(s)
_____

_____
Any Significant Injury/Medical Illness History?
_____

Type of Injury/Illness_____

_____

I hereby certify, as practicing physician in the State of New Jersey, that the applicant is physically (FIT) (UNFIT) to become a member of the Rumson First Aid Squad of the Borough of Rumson, New Jersey.

Date: _____ Doctor's Name: _____

_____ Address: _____
Doctor's Signature

                                                        _____

_____

(**FOR EMS USE ONLY**)
                                        SQUAD RECORDS

BOARD OF TRUSTEES:

        DATE OF INTERVIEW_____COMMENTS_____

                                                        _____

_____
Signature of Presiding Member
_____

Date Application Received: _____ Date Accepted: _____

Reason for NOT Accepting: _____

Date of Exemption: _____Date of Termination: _____

Date of Leave: _____Date of Return: _____