

Englishtown-Manalapan First Aid Squad

P.O. Box 294, 11 Sanford Avenue, Englishtown, NJ 07726

Application for Membership **Date:** ___/___/___

Please print all information clearly – DO NOT TYPE

NAME: _____ **SS#:** _____

HOME TELEPHONE #: (____) _____ - _____

CELL #: (____) _____ - _____

EMAIL: _____

CURRENT ADDRESS:

STREET: _____

TOWN: _____

STATE: _____ **ZIP CODE:** _____

HOW LONG AT THIS ADDRESS: _____

HOW LONG AT THIS STATE: _____

PRIOR ADDRESS:

STREET: _____

TOWN: _____

STATE: _____ **ZIP CODE:** _____

HOW LONG AT THIS ADDRESS: _____

HOW LONG AT THIS STATE: _____

PLACE OF BIRTH: _____ **DATE OF BIRTH:** _____

ARE YOU RELATED TO ANYONE ON A FIRST AID SQUAD? _____

HOW DID YOU LEARN ABOUT US? _____

IN YOUR OWN WORDS WHY ARE YOU JOINING THE SQUAD?

HAVE YOU BEEN PREVIOUSLY ACCEPTED BY A FIRST AID SQUAD?

(PLEASE LIST SQUAD NAMES AND DATES OF SERVICE AND OR REASONS FOR LEAVING)

HAVE YOU EVER BEEN SUSPENDED OR TERMINATED FROM ANOTHER SQUAD?

(IF YES PLEASE DETAIL WHY & WHAT THE DATE OF OCCURANCE WAS)

HAVE YOU EVER BEEN ARRESTED OR CONVICTED FOR VIOLATING ANY LAW OR ORDINANCE IN ANY STATE?

(IF YES PLEASE DETAIL WHY & WHAT THE DATE OF OCCURANCE WAS)

HAVE YOU EVER PLED GUILTY TO, BEEN CONVICTED OF ANY VIOLATION, LAW OR ORDINANCE IN ANY STATE?

(IF YES PLEASE DETAIL WHY & WHAT THE DATE OF OCCURANCE WAS)

HAVE YOU EVER BEEN BONDED? : _____

HAVE YOU EVER BEEN REFUSED A BOND? : _____

DO YOU HAVE A VALID DRIVERS LICENSE?:

(IF YES PLEASE INCLUDE A COPY OF FRONT AND BACK)

AUTO YES _____ NO _____ HOW LONG? _____ YRS.
CDL YES _____ NO _____ HOW LONG? _____ YRS.

DRIVERS LICENSE NUMER: _____

HAVE YOU HAD ANY ACCIDENTS IN THE LAST THREE 3 YEARS?: _____

TOTAL POINTS AGAINST LICENSE: _____

HAVE YOU EVER HAD YOUR LICENSE SUSPENDED?: _____

**** EDUCATIONAL HISTORY ****

NAME & LOCATION	YRS ATTENDED	YR GRADUATED
GRAMMAR SCHOOL		
HIGH SCHOOL		
VOCATIONAL SCHOOL		
COLLEGE OR UNIVERSITY		

MAJOR COURSES STUDIED: _____

NOW STUDYING: _____ **WHERE?:** _____

FURTHER EDUCATION OR TRAINING DESIRED: _____

DO YOU HAVE ANY SPECIAL QUALIFICATIONS OR TECHNICAL TRAINING?:
(PLEASE INCLUDE COPIES OF CERTIFICATIONS)

HAVE YOU EVER HAD PARA MEDICAL TRAINING?
(PLEASE INCLUDE COPIES OF CERTIFICATIONS)

DATE RECEIVED: _____ **EXPIRATION DATE:** _____

WHEN ARE YOU AVAILABLE TO RIDE CREW AS A PROBATIONARY MEMBER?
(PLEASE SPECIFY DAY, EVE, NIGHT CREW)

PLEASE LIST ANY OTHER ORGANIZATIONS TO WHICH YOU BELONG:
(IF ANY)

HAVE YOU EVER HAD FIRST AID TRAINING?
(IF YES PLEASE LIST TRAINING AND INCLUDE COPIES OF ALL CERTIFICATIONS)

**** EMPLOYMENT HISTORY ****
(PLEASE LIST MOST RECENT FIRST)

EMPLOYER: _____

POSITION HELD: _____ **START DATE:** _____ **END DATE:** _____

SUPERVISOR NAME: _____ **PHONE:** _____

REASON FOR LEAVING: _____

EMPLOYER: _____

POSITION HELD: _____ **START DATE:** _____ **END DATE:** _____

SUPERVISOR NAME: _____ **PHONE:** _____

REASON FOR LEAVING: _____

EMPLOYER: _____

POSITION HELD: _____ **START DATE:** _____ **END DATE:** _____

SUPERVISOR NAME: _____ **PHONE:** _____

REASON FOR LEAVING: _____

**** MEDICAL HISTORY ****

APPLICANTS NAME: _____

EPILEPSY / SEIZURES: _____

DIABETES: _____

HEART: _____

FAINING: _____

TUBERCULOSIS: _____

RHUEMATISM: _____

KIDNEY: _____

OTHER: _____

BACK PROBLEMS: _____

HERNIA: _____

ABDOMEN: _____

COLOR VISION: _____

HEARING: _____

RESPIRATORY: _____

COMMUNICABLE: _____

BLOOD PRESSURE: _____

EXTREMITIES: _____

VISION: _____ **(MIN 20/40 WITH CORRECTIVE LENSES):** _____

HIV: _____

HEPATITIS: _____

HABITS: ALCOHOL: _____ **DRUGS:** _____ **CIGARETTES:** _____ **OTHER:** _____

CURRENT MEDICATIONS: _____

LABORATORY: _____

RECOMMENDATIONS: _____

DUE TO THE NATURE OF THE SQUAD DUTIES, THE ABOVE NAMED IS ABLE TO PERFORM THE FOLLOWING IN MY PROFESSIONAL OPINION:

_____ **LIFT AND CARRY AT LEAST 100LBS.
WORK IN CONTINUOUS AND STRENUOUS MOVEMENTS
IN GOOD HEALTH IN MY PROFESSIONAL OPINION**

PHYSICIAN NAME PRINTED

PHYSICIANS ADDRESS:

SIGNED: _____

PHYSICIAN'S SIGNATURE

**** PERSONAL & PHYSICAL DATA ****

APPLICANTS NAME: _____

HEIGHT: _____

WEIGHT: _____

PHYSICAL DEFECTS: _____

MILITARY SERVICE - (IF ANY):

ENTERED: _____

RELEASED: _____

BRANCH: _____

RANK WHEN RELEASED: _____

MARRIED: _____

SINGLE: _____

WIDOWED: _____

SIGNIFICANT OTHERS:

NAME: _____

STREET: _____

TOWN: _____

STATE: _____

ZIP CODE: _____

HOME PHONE: _____

CELLULAR PHONE: _____

PLEASE LIST NAMES AND AGES OF CHILDREN:

NAME: _____

AGE: _____

NAME: _____

AGE: _____

NAME: _____

AGE: _____

NAME: _____

AGE: _____

EMERGENCY CONTACT DATA:

(PLEASE LIST ATLEAST TWO EMERGENCY CONTACTS)

NAME: _____
STREET: _____
TOWN: _____
STATE: _____ **ZIP CODE:** _____
HOME PHONE: _____ **CELLULAR PHONE:** _____

NAME: _____
STREET: _____
TOWN: _____
STATE: _____ **ZIP CODE:** _____
HOME PHONE: _____ **CELLULAR PHONE:** _____

NAME: _____
STREET: _____
TOWN: _____
STATE: _____ **ZIP CODE:** _____
HOME PHONE: _____ **CELLULAR PHONE:** _____

***** DO NOT WRITE BELOW THIS LINE *****

=====

TO BE FILLED IN BY MEMBERSHIP SECRETARY

DATE RECEIVED: _____

DATE ACTED ON: _____

DATE APPROVED BY INVESTIGATION COMMITTEE: _____

DATE OF PROBATION: _____

DATE OF SENIOR: _____

DATE RETIRED: _____

COMMENTS: _____

DECLINATION STATEMENT FOR:

APPLICANTS NAME

***** DECLINATION STATEMENT FOR HEPATITIS – B IMMUNIZATION *****

I understand that due to the occupational exposure to blood or other potentially infectious materials, I may be at risk of the acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to myself. However, I decline the 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 the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

****** IF APPLICANT IS UNDER THE AGE OF 18 PLEASE HAVE A PARENT OR LEGAL GAURDIAN CO SIGN BELOW ******

PRINT NAME

PRINT NAME

SIGN NAME

SIGN NAME

DATE

DATE

BACKGROUND CHECK INFORMATION FOR ENGLISHTOWN MANALAPAN TOWNSHIP FIRST AID

Call and make an appointment with the Manalapan police (732-446-4300) to have a background check done. These appointments are available on varying weekdays between 5pm and 10pm.

Tell them that you are looking to join the Englishtown Manalapan First Aid Squad and need a background check done.

Manalapan Township Police is located on the corner of Taylors Mills Rd. and Route 522.

**** PLEASE NOTE THAT THE BACKGROUND CHECKS TAKE A LITTLE WHILE TO PROCESS. You will be notified once they are returned to the Squad.**

**** WHILE YOU ARE WAITING FOR THE RETURN OF THE BACKGROUND CHECKS YOU CAN STILL RIDE ON THE AMBULANCE AS A RIDE-A-LONG. PLEASE FILL OUT THE RIDE-A-LONG FORM (MUST BE NOTORIZED) AND RETURN TO THE 2ND LT. (732-850-6488) ALONG WITH YOUR AVAILABILITY SHEET.**

DRIVER HISTORY REPORT

A driver history report is also required for driving privileges on the squad. Prior to beginning your driver training with the squad you must get a copy of your drivers' history. This can be done in two ways:

1. Go to the Eatontown DMV and fill out the applicable form to receive a driver history report. *Or*
2. Go online to the New Jersey DMV commission and click on request driver history report.

There is a \$10 fee associated with this report that the member will pay for. If possible, have report mailed directly to the squad at:

Englishtown-Manalapan FAS
PO Box 294
Manalapan, NJ 07726

ENGLISHTOWN – MANALAPAN FIRST AID SQUAD
7 SANFORD AVE.
ENGLISHTOWN, N.J. 07726
732-786-0133