



North Haledon Volunteer Ambulance, Inc.

792 Belmont Avenue, North Haledon, New Jersey 07508

(973) 423-0141 <http://nhems.org>

APPLICATION FOR MEMBERSHIP

Date: _____

Name: _____ Age: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: () _____ Type: Home, Cell, Office

Email: _____

Occupation: _____ Hours of Employment: _____

Employer's Name _____

Address: _____ Phone Number () _____

City: _____ State: _____ Zip Code: _____

Driver's License Number _____ Expiration: _____

Education Completed: _____ Best Time for Interview _____

Military Service: YES NO If Yes, Which Branch: _____

List All First Aid Certificates you now hold (supply copies of these certificates) _____

1. Are you now attending school _____ YES _____ NO
2. Do you plan on attending school _____ YES _____ NO
3. Are you in possession of a VALID New Jersey License? _____ YES _____ NO
4. Has your driver's license ever been suspended or revoked? _____ YES _____ NO
(If YES give dates and specific details on back)
5. Have you ever been involved in any moving violations _____ YES _____ NO
(If YES give dates and specific details on back)
6. Have you ever been convicted of a crime? _____ YES _____ NO
(If YES give dates and specific details on back)
7. Have you ever been bonded? _____ YES _____ NO
(If YES give dates and specific details on back)
8. Have you ever refused bonding? _____ YES _____ NO
(If YES give dates and specific details on back)



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List Names of Organizations that you may belong to: _____

Do you currently, or have you held offices in any of the above organizations? _____ YES _____ NO

If YES, what offices _____

Why do you wish to join NHVA? _____

Would you be willing to hold office in NHVA? _____ YES _____ NO

Hours Available to be "ON CALL" _____

Will you be able to attend the necessary meetings _____ YES _____ NO

Have you ever had an alcohol problem? _____ YES _____ NO

Have you ever had a drug problem? _____ YES _____ NO

Do you take any medications regularly? _____ YES _____ NO

NOTES: _____



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Names of THREE (3) Individuals, NOT relatives, to be used for references

1.
Name: _____ Phone Number: () _____

Address: _____

City: _____ State: _____ Zip Code: _____

Number of years you have known this person: _____

2.
Name: _____ Phone Number: () _____

Address: _____

City: _____ State: _____ Zip Code: _____

Number of years you have known this person: _____

3.
Name: _____ Phone Number: () _____

Address: _____

City: _____ State: _____ Zip Code: _____

Number of years you have known this person: _____



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Date: _____

Print Name: _____

I the undersigned do swear that all the answers given on the application and said at the investigation are true to the best of my knowledge and belief.

It is understood that any false statement on this application or to the investigation committee is sufficient cause for rejection or dismissal of said application.

All questions that I have asked have been answered in full, as well, I have answered in full all the questions asked of me. I understand what will be required of me as well as what the Association will provide me with.

I understand that if I am accepted that I may be in a probationary period, not to exceed 6 months.

I agree to comply with all rules and regulations of North Haledon Volunteer Ambulance.

If for any reason, I resign, am expelled, dismissed or dripped from the rolls of this organization, I agree to return all property issued to me by North Haledon Volunteer Ambulance within thirty (30) days.

Signature: _____ Date: _____

Investigation Committee: _____

Parental Permission (if applicant is a minor): _____



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Medical Release and Physical Form

Doctor Morone
220 Hamburg Turnpike
Wayne New Jersey 07470
(973) 942- 5230

Date: _____

Family Physician Name: _____ Phone Number: () _____

Address: _____

City: _____ State: _____ Zip Code: _____

I, _____ Hereby give permission and consent to the North Haledon Volunteer Ambulance, Inc. to secure any medical information from my physical.

Signature: _____

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

List any Medical History: _____

Do you Now, or have you ever had:

Heart Problems	___ YES ___ NO	Explain _____
Seizures	___ YES ___ NO	Explain _____
Hearing Difficulty or Impairment	___ YES ___ NO	Explain _____
Fainting Spell	___ YES ___ NO	Explain _____
Eye Problems	___ YES ___ NO	Explain _____
Back Problems	___ YES ___ NO	Explain _____

I have examined the above applicant and certify that to the best of my knowledge he/she is physically
___ FIT / ___ UNFIT (PLEASE MARK ONE) **for ambulance duty.**

Signature: _____ Date: _____

Comments: _____



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APPLICATION FOR MEMBERSHIP Officers' Review Form

Date: _____

Print Applicant's Name: _____

Phone Number () _____ Second Phone Number () _____

Applicant Checklist

1. Application filled out ___ Yes ___ No
2. Medical Release Obtained ___ Yes ___ No
3. Criminal Record / Background Release filled out ___ Yes ___ No
- 4 Background Check and Fingerprints complete ___ Yes ___ No
5. Copies of First Aid Certificates provided ___ Yes ___ No

Is the Applicant Recommended? ___ Yes ___ No Date: _____

If YES : Applicant scheduled to appear before Mayor and Council on:

If NO: Reasons _____

Investigation Committee Signatures:

- | | | |
|--------------------------|--------------------|---------------|
| 1. _____
Printed Name | _____
Signature | _____
Date |
| 2. _____
Printed Name | _____
Signature | _____
Date |
| 3. _____
Printed Name | _____
Signature | _____
Date |