



SIMSBURY VOLUNTEER AMBULANCE ASSOCIATION
PO BOX 301, SIMSBURY, CT 06070
860-658-7213

APPLICATION FOR MEMBERSHIP

The undersigned hereby applies for membership in the Simsbury Volunteer Ambulance Association, Inc. (SVAA) and provides the following information:

NAME : _____ **DATE OF BIRTH :** _____

ADDRESS & TOWN: _____ **SOC. SEC. NUMBER:** _____

E-Mail: _____ **Cell Phone #:** _____ **Home Phone #:** _____

CT OPERATOR LIC. NO. _____ **IS YOUR LIC. VALID?** _____

VEHICLE INFORMATION: MAKE/MODEL/COLOR _____
 LIC. PLATE _____ VEHICLE ID NO. _____

HAS YOUR VEHICLE INSURANCE EVER BEEN CANCELED OR DECLINED?
 NO _____ YES _____ If yes, explain _____

HAVE YOU HAD ANY MOTOR VEHICLE VIOLATIONS IN THE PAST FIVE YEARS? NO _____
 YES _____ If yes, explain _____

HAVE YOU EVER BEEN ARRESTED? NO _____ YES _____ If yes, explain _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS WHICH COULD AFFECT YOUR ABILITY TO
 PERFORM ATTENDANT OR DRIVER DUTIES? NO _____ YES _____
 If yes, explain _____

EMT INFORMATION:
 STATE OF CT EMT NUMBER: _____ EXPIRATION DATE: _____
 WHERE WAS THE EMT COURSE TAKEN? _____

IF NOT CURRENTLY CERTIFIED, WHERE ARE YOU ENROLLED IN A CLASS?

(OVER PLEASE)

AVAILABILITY FOR SCHEDULING:

Please list your availability for scheduling, i.e., days available, daytime (6a-6p), evenings (6p-6a), week-ends, etc. If you are available for half shifts (i.e. 6a-noon) please list.

DAYS	6A -6P	6P – 6A
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

READ CAREFULLY BEFORE SIGNING:

BY SIGNING BELOW I AGREE, IF ACCEPTED TO MEMBERSHIP IN SVAA, TO BE BOUND BY THE LAWS AND STANDARD OPERATING PROCEDURES OF THE SIMSBURY VOLUNTEER AMBULANCE ASSOCIATION, ICN. AND I FURTHER STATE THAT THE INFORMATION ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT FALSE OR MISLEADING INFORMATION ON THIS APPLICATION MAY BE THE BASIS FOR DENIAL OR TERMINATION OF MEMBERSHIP. I FURTHER UNDERSTAND THAT ACCEPTANCE INTO MEMBERSHIP IS AT THE SOLE DISCRETION OF THE BOARD OF DIRECTORS OF SVAA.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

FOR OFFICE USE ONE, DO NOT COMPLETE
COPIES ON FILE OF CURRENT:

DRIVER LICENSE _____

EMT CARD _____

CPR CARD _____

SIMSBURY VOLUNTEER AMBULANCE ASSOCIATION, INC.

**P.O. BOX 301, SIMSBURY, CT 06070
PHONE: 860-658-7213 FAX: 860-658-4987**

I, _____, hereby authorize Simsbury Volunteer Ambulance Association, Inc. to request all, if any, police records, documents or information pertaining to me. I further agree to hold harmless the Simsbury Volunteer Ambulance Association, Inc. from any and all claims arising out of the utilization of information obtained with this authorization.

Operator's Number and State

Date of Birth

Present Street Address

Previous Street Address

City and State

Previous City and State

Applicant Signature

SVAA Executive Director:

Print Name

Signature

Date



Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained.

Questions:

Name: _____
 Address: _____
 City & State: _____ Zip: _____
 Full Time Occupation: _____
 Name of Organization: _____
 Position/Title: _____
 Social Security No. _____
 What is your Valid State Operators Plate No. _____

REMARKS: If any question is answered, "YES," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

1. **Birth Date:** Month: _____ Day: _____ Year: _____

2. **Eyesight:**

	Yes	No
a. Have you lost use of either eye? _____ R _____ L.....a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Is peripheral (side) vision restricted?.....b.	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you color blind?c.	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you have, or have you ever had, cataracts?d.	<input type="checkbox"/>	<input type="checkbox"/>
e. Are actual deficiencies corrected by glasses or contact lenses?...e.	<input type="checkbox"/>	<input type="checkbox"/>
f. Date of last eye examination:f.		_____

3. **Hearing:**

a. Do you have difficulty hearing normal conversation level?.....a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you use a hearing aid?b.	<input type="checkbox"/>	<input type="checkbox"/>

4. **Diabetes:**

a. Have you ever been treated for diabetes?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Describe current medication and dosage, if any, and method of administration under "remarks."		
c. Date of latest blood sugar test:c.		_____

5. **Heart:**

a. Have you ever been treated for heart disease?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Describe condition:.....b.		
c. Describe current medication and dosage, if any, under "remarks."		
d. Do you have a pacemaker?d.	<input type="checkbox"/>	<input type="checkbox"/>
e. Date of last treatment or check-up:e.		_____

6. **Epilepsy:**

a. Have you ever been treated for epilepsy?.....a.	<input type="checkbox"/>	<input type="checkbox"/>
b. If "Yes," when was your last seizure?.....b.		
c. Describe current medication and dosage, if any, under "remarks."		

Questions:

REMARKS:

- 7. Blood Pressure:**
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Have you ever been treated for high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when were you treated? | _____ | |
| c. What was your last reading? | _____ | |
| d. Describe current medication and dosage, if any, under "remarks." | | |
- 8. Limbs:**
- | | | |
|--|--------------------------|--------------------------|
| a. Have you lost an arm or leg? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you lost the use of an arm or leg?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does vehicle have special controls? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes" to any of the above, describe under "remarks." | | |
- 9. Miscellaneous:**
- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever had, or been treated for, Convulsions? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| c. Have you ever had any Fainting Spells? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| e. Have you ever had, or been treated for, Loss of Equilibrium?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| g. Have you ever been treated for Alcohol or Drug Abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| i. Have you ever been treated for Mental Illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
- 10. What is the date of your last physical examination?** _____
- 11. Are there any restrictions posted on your vehicle operator's license?**
- 12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?**
- 13. When and for what purpose, did you last consult a doctor?**

- 14. Full Name, address and telephone number of your personal physician.**
 Name: _____
 Address: _____
 City & State: _____ Zip: _____

The answers to the above are complete, accurate, and true to the best of my knowledge.

Signature of Person Named Above	Date
---------------------------------	------

Authorization For Release

"I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give _____ Department/Company any such information."

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

Signature of Person Named Above	Date
---------------------------------	------