

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 ADDRESS: _____ 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
(For Cadet Applications)

Date of Application

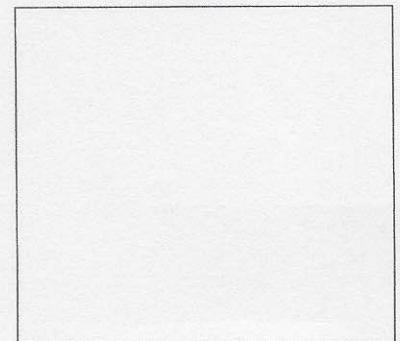
STATE OF NEW JERSEY, COUNTY OF MONMOUTH

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 Signature

Notary Seal



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: _____