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 (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 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: _____