

Blairstown Ambulance Corps

P.O. BOX 389, BLAIRSTOWN, NEW JERSEY 07825

PHONE: (908) 362-9363

www.46Rescue.org



*A volunteer non-profit EMS organization serving
Blairstown, Hardwick, Hope and parts of Frelinghuysen Townships.*

Date: _____

MEMBERSHIP APPLICATION

Name _____ Date of Birth _____

Address _____
Street/P.O. Box _____ Town _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____ SS# _____

Length of time at above address _____

Length of time in New Jersey _____

Prior Address _____
Street/P.O. Box _____ Town _____ Zip Code _____

Length of time at prior address _____

Membership type applying for: _____ Regular _____ Cadet (16 or 17 years old) _____ Driver

Place of Birth _____

Name of Spouse/Closest Relative _____ Relationship _____

Address _____
Street/P.O. Box _____ Town _____ Zip Code _____

Are you related to anyone in a First Aid Squad _____

Name & Address _____
Street/P.O. Box _____ Town _____ Zip Code _____

Do you know anyone of the Blairstown Ambulance Corps & how _____

Have you ever been accepted/rejected by a First Aid Squad Yes No

If yes, please give details _____

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Have you ever been arrested or convicted of a crime Yes No

If yes, Please give details _____

Have you ever been bonded Yes No Refused bond Yes No

Do you have a valid driver's license Yes No License Number _____

State of issue _____ Length of time licensed _____

CDL license Yes No What Class _____

Motor boat license Yes No Points against license _____

License ever suspended in any state or country Yes No

Any accidents in the past 3 years Yes No

Auto Insurance Carrier _____ Policy # _____

Membership Recommended by _____

EDUCATION

| School name & location | Years attended | Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No | Major |
|------------------------|----------------|---|-------|
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Further education or training desired _____

Now studying _____ Where _____

Have you any special qualifications or technical training _____

Employment History

Present Employer _____

Address _____

Date Employed _____ Position held _____

Immediate Supervisor _____ Phone # _____

Previous Employer _____

Address _____

Date from _____ to _____ Position held _____

Immediate Supervisor _____ Phone # _____

Previous Employer _____

Address _____

Date from _____ to _____ Position held _____

Immediate Supervisor _____ Phone # _____

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MILITARY SERVICE

Branch _____ Rank when discharged _____

Date of discharge _____ Type of discharge _____

Past History

Habits: Alcohol Yes No Drugs Yes No Smoking Yes No

Have you ever held any of the following certifications?

| Certification | | Date card issued | Expiration date |
|-----------------|--|------------------|-----------------|
| CPR | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Basic First Aid | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| First Responder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| EMT | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Paramedic | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you have any other medical training? Yes No

If yes, explain _____

A copy of all valid health care cards and driver's license must accompany this application and original cards must be presented at time of your interview.

When are you available for duty/activities _____

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REFERENCES

Give four references, other than relatives or squad members:

Please notify your references prior to returning application.

| Name | Address | Occupation | Phone # | Relation |
|------|---------|------------|---------|----------|
|------|---------|------------|---------|----------|

APPLICANT'S DECLARATION

If accepted under this application, I agree to comply with all orders, rules and regulations of the Corps.

The answers to the foregoing are in my own handwriting and are true to the best of my knowledge and belief. It is understood that any false statements on this application is sufficient for rejections or dismissal.

I hereby authorize the Blairstown Ambulance Corps to have access to all of my hospital and medical records, driving record and criminal record. I understand that if I am chosen to serve with the Blairstown Ambulance Corps, I will be on Probation for one (1) year after completion of the Blairstown Ambulance Corps mandatory training during which I may be terminated for any reason.

Applicant Signature _____ Date _____

If under 18 Parent or Guardians Signature _____ Date _____

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PHYSICAL FINDINGS

Must be completed by a physician. Please determine the applicant's physical fitness. This applicant is being considered for membership in the Blairstown Ambulance Corps and will be working in the area of health care in emergency response situations.

Name _____ Date _____

Height _____ Weight _____ Blood Pressure _____

| | | | | | |
|------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|
| Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vision issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abdomen issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Throat issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Extremity issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Habits: Alcohol Yes No Drugs Yes No Smoking Yes No

Back problems/Injury history _____

Ability to lift, pull, push & carry weights over 50 lbs Yes No

Please determine the applicants physical fitness _____

Your recommendations _____

Physician's Signature _____

Physician's Name (print) _____ Phone # _____

Address _____

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