



## BEACHWOOD FIRST AID SQUAD APPLICATION

<b>1</b>	Last name	First	Middle	Date of Birth	<b>2</b>	Social Security Number
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<b>3</b>	Mailing address			<b>4</b> Phone numbers (include area code)		
				Daytime	( )	
	City	State	ZIP Code	Other	( )	
			-	<b>6</b>	EMAIL	
<b>5</b>	How long at this address?	If less than 5 Years, list previous addresses and how long you've resided there.				

### EXPERIENCE

<b>7</b>	Describe any Volunteer or Work experience related to the medical field.					
<b>a</b>						
<b>b</b>						

<b>8</b>	Have you ever been a member of a First Aid Squad? YES <input type="checkbox"/> NO <input type="checkbox"/>					
	If YES list Squad and Address					
	Office Held and duration?					

<b>9</b>	Do you have any Para-medical Training? YES <input type="checkbox"/> NO <input type="checkbox"/>					
	If YES explain					
<b>a</b>	Do you or have you, ever held an EMT card? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES explain what type and when below.					
	Expiration Date					
<b>b</b>	Do you or have any special skills or training? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES explain what type below.					

### Civil Information

<b>10</b>	Have you ever been arrested in violation of any law or ordinance? Include Traffic Violations. YES <input type="checkbox"/> NO <input type="checkbox"/>					
	If YES list date, offence and details					

<b>11</b>	Have you ever been convicted of a felony? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	If YES provide details	

<b>12</b>	Do You have a valid New Jersey Drivers License? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES Lic #	
<b>a</b>	Have you had a reportable accident in the last three years? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES explain below	
<b>b</b>	Has your license been suspended in the last three years? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES explain below	
<b>c</b>	Do you have any points against your license? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES how many?	

**Availability**

<b>13</b>	When are you available for Squad activities?	
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**Employment**

<b>14</b>	Are you currently employed? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	If YES list Employer, Address and date of employment, if employed less than 1 year put previous employer in section b	
<b>a</b>	Employer Name	
	Address	
	Date Hired	
	Supervisor Contact	
<b>b</b>	Employer Name	
	Address	
	Date Hired	
	Supervisor Contact	
<b>c</b>	May we contact your current supervisor? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	If we feel the need to contact your current supervisor, <b>we will</b> inform you first.	

**Education**

<b>15</b>	Mark highest level completed. Some HS <input type="checkbox"/> HS/GED <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate <input type="checkbox"/>
<b>a</b>	If Secondary Education is selected state major

**References**

<b>16</b>	Provide three references other than family members			
	Name	Address	Phone	Relationship

**Information Request**

The nature of our service often takes us into the homes and automobiles during times of great stress and confusion. Occasionally, valuable personal property will be lost or mislaid by the victims or their families during these times. Under these circumstances, it is imperative that the members of **Emergency Medical Service** crews be above suspicion. Because of this, your application for membership in the Beachwood First Aid Squad does contain questions of a personal nature and does require references. Your acceptance into the Squad is contingent upon the verification of the information and completion of a background investigation. We regret that this is necessary, but we know of no alternative. All information will be kept strictly confidential.

**Applicant Certification**

**I certify** that, to the best of my knowledge and belief, all of the information on and attached to this application is true, correct, complete and made in good faith. **I understand** that false or fraudulent information on or attached to this application may be grounds for rejection or dismissal. If acceptance is obtained under this application, **I agree** to comply with all orders, rules and regulations of this Squad. **I further agree** that acceptance is contingent upon passing a physical examination and **I consent to provide my fingerprints** in order to complete a routine background investigation.

<b>Applicant Signature</b>	<b>DATE</b>
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<b>Witness Signature</b>	<b>Printed Name</b>
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**For Squad use only**

<b>Date received</b>		<b>Date acted on</b>	
<b>Date physical received</b>		<b>Date background check complete</b>	
<b>Date reference check complete</b>		<b>Membership approval date</b>	
<b>Probation start date</b>		<b>Regular membership date</b>	
<b>Retired date (all forms)</b>			

<b>Comments</b>	
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**For Police use only**

<b>Comments</b>	
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## PHYSICAL EXAM

### BEACHWOOD FIRST AID SQUAD

**To the examiner: Please review the applicant's verbal history and complete the physical examination. Please comment on any positive answers.**

Last name	First	Middle Initial	Date of Birth	SEX	Social Security Number
				M F	
Street Address			City	State	Zip
Blood Pressure	Pulse	Height (inches)	Weight (lbs)		

**Are there any abnormalities in the following systems? If the answer is yes, please describe fully in the comments section. An additional comment sheet may be used if necessary.**

System	Yes	No	Comments
Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Skin			
Psychiatric			

If the answer is yes to any question please describe below	Yes	No
Is the patient now under treatment for any medical or emotional condition?		
Is the patient currently taking any medication?		
Is there a loss or serious impairment of function of any organ?		
Is there any restriction to physical activity?		
Do you have any additional comments on the condition of this patient?		

**Comments**

  
  
  
  
  
  
  
  
  
  

Health Care Provider	Address
Phone Number	Examiners Name
Examiners Signature	Date