LEHIGHTON AMBULANCE ASSOCIATION, INC.

VOLUNTEER QUESTIONNAIRE

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Lehighton Ambulance Association, Inc. recognizes that all persons are entitled to equal employment opportunities, and in its recruitment for employment or volunteers, training and compensation practices, the best qualified individual, based on organizational requirements, shall be selected, without regard to race, creed, color, sex, or national origin, as well as mental and physical handicaps that do not interfere with job performance.

NAME: _____DATE:_____
(Last) (First) (MI)

ADDRESS:_____
(Street/P.O. Box) (City) (State) (ZipCode)

DATE OF BIRTH _____

Pager/Cell Number (_____)_____ Carrier:_____

TELEPHONE NUMBER:(_____)_____SOCIAL SECURITY #:_____

Email address:_____

POSITION DESIRED: _____ _____ VOLUNTEER

HAVE YOU EVER PLEADED OR BEEN CONVICTED OF A CRIME OTHER THAN A MISDEMEANOR OR SUMMARY OFFENSE? YES_____ NO_____

IF YOU HAVE BEEN CONVICTED OF A FELONY, THE NATURE OF THE FELONY AND THE LENGTH OF TIME SINCE CONVICTION WILL BE IMPORTANT EMPLOYMENT CONSIDERATIONS. YOU WILL NOT BE AUTOMATICALLY DISQUALIFIED FOR EMPLOYMENT BY LAA,INC. BECAUSE OF A PRIOR CONVICTION AND YOU WILL BE GIVEN THE OPPORTUNITY TO EXPLAIN ANY CONVICTIONS.

HAVE YOU EVER BEEN FIRED FROM A JOB FOR ANY REASON? YES_____ NO_____

IF YES, EXPLAIN:_____

IF YOUR APPLICATION IS CONSIDERED FAVORABLY, ON WHAT DATE WILL YOU BE AVAILABLE?_____

EDUCATION

HIGH SCHOOL: NUMBER OF YEARS COMPLETED: 1 2 3 4

SCHOOL:_____ CITY:_____ STATE:_____

DO YOU HAVE A HIGH SCHOOL DIPLOMA? YES_____ NO_____ (OR) GED YES____ NO_____

COLLEGE: NUMBER OF YEARS COMPLETED: 1 2 3 4 5

SCHOOL:_____CITY:_____STATE:_____

MAJOR:_____DEGREE:_____

OTHER TRAINING:

SCHOOL:_____CITY:_____STATE:_____

COURSE:_____DEGREE EARNED:_____

EMERGENCY MEDICAL SERVICES TRAINING:

HIGHEST LEVEL OF TRAINING: FIRST RESPONDER_____EMT_____

OTHER_____PARAMEDIC_____HEALTH PROFESSIONAL_____

DATE OF ORIGINAL CERTIFICATION:_____

LOCATION OF ORIGINAL FIRST RESPONDER/EMT/PARAMEDIC/HPRN TRAINING:

SCHOOL:_____CITY:_____STATE:_____

HAS YOUR CERTIFICATION EVER LAPSED? YES_____ NO_____ N/A_____

IF YES, E XPLAIN_____

HAVE YOUR MEDICAL COMMAND PRIVILEGES EVER BEEN SUSPENDED? YES_____ NO_____N/A____

IF YES, EXPLAIN_____

IS THERE ANY LEGAL, MALPRACTICE OR DISCIPLINARY ACTION PENDING AGAINST YOU? YES____NO_____N/A_____

IF YES, EXPLAIN:_____

CURRENT EMS REGION IN WHICH YOU SERVE: _____

CURRENT MEDICAL DIRECTOR'S NAME: _____TELEPHONE NUMBER:_____

ADDRESS:_____
(STREET/P.O. BOX) (CITY) (STATE) (ZIP CODE)

CERTIFICATIONS WITH COPIES ATTACHED TO APPLICATION:

DRIVER'S LICENSE: DR. ID #_____ EXP.DATE _____

EVOC DATE TAKEN_____

(Circle One) **FR** **EMT** **PII** **HP**

CERT#_____ DATE_____ 3 DIGIT_____

CPR EXPIRATION DATE _____

ACLS EXPIRATION DATE _____

PHTLS EXPIRATION DATE_____

PALS EXPIRATION DATE_____

HAZ MAT R & I EXPIRATION DATE OR DATE TAKEN_____
(CIRCLE ONE)

HEPTAVAX Y or N DATE TAKEN_____ _

TB TESTING Y or N DATE TAKEN_____

BLOOD BORNE PATHOGEN IN SERVICE DATE TAKEN_____

PROFESSIONAL REFERENCES

(1.) FULL NAME_____

ADDRESS_____

PHONE NUMBER_____

OCCUPATION_____

(2.) FULL NAME_____

ADDRESS_____

PHONE NUMBER_____

OCCUPATION_____

(3.) FULL NAME_____

ADDRESS_____

PHONE NUMBER_____

OCCUPATION_____

TO THE APPLICANT: READ CAREFULLY BEFORE SIGNING

I certify that all data provided on this application is true and accurate. I understand that it will be carefully checked and that misrepresentation or omission of facts on my part may be justification for separation from the Organization's services, if employed or accepted into membership.

I authorize you or my former employers or references to furnish any information concerning my personal background check or employment record . I hereby release from liability the company and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information. I understand that if membership is obtained under this application, the organization does not guarantee membership for a fixed term.

This application is current for only 60 days. At the conclusion of this time, if I have not heard from the company and still wish to be considered for membership, it will be necessary to fill out a new application

I understand that I am free to resign at any time, the company reserves the right to terminate my membership at any time, with or without cause and without prior notice. I understand that no representative of the company has the authority to make any assurances to the contrary.

I hereby agree to submit to a physical examination if requested by the organization and I attest to the fact that I am now physically capable of performing all responsibilities within the scope of the position for which I applied and understand that some heavy lifting will be required as part of an ambulance service.

_____ _____

(Signature) (Date)

Please complete the following as it will be reviewed by the membership committee:

I would like to volunteer at Lehighton Ambulance because:_____

_____

**** use other side of this page if you need more room.

P.O Box 82
516 Iron Street
Lehighton, PA 18235

Phone #(610)377-5155 FAX # (610)377-5576

LEHIGHTON AMBULANCE ASSOCIATION
516 IRON STREET
P O BOX 82
LEHIGHTON, PA 18235
610-377-5155 FAX 610-377-5576

RELEASE FORM

I _____grant permission for the Lehighton Ambulance Association to obtain a Motor Vehicle Drivers history report and a Criminal History report, as often as required, or as deemed necessary, for as long as I am employed or volunteer for Lehighton Ambulance Association.

APPLICANT

NAME _____
Last First Middle Name

Maiden Name or Aliases

_____

Address:_____

Social Security:_____

Date of Birth:_____ _____ _____

Operator License Number _____

Signature:_____
Applicant MVR History