Atlantic Highlands First Aid & Safety Squad, Inc.

Application for Membership

Fill in the following fields, print and bring to a Notary Public.

Applicant Information

Name:		
Date of Birth:	SSN:	Phone:
Current Address:		
City:	State:	Zip:
Driver's License Number:		
E-Mail Address:		

Employment Information

Current Employer:	
Employer Address:	
Phone Number:	E-Mail:
Position:	

Emergency Contact

Name:		
Address:		
City:	State:	Zip:
Relationship:		Phone:

Background Information

Have you ever been arrested?
If yes, please explain:
Have you ever been convicted of a crime?
If yes, please explain:
List any traffic violations:

Prior Experience

Have you ever been a member of a first aid squad before?
If yes, what squad?
Are you still a member in good standing?
If no, please explain:

If accepted as a member, I understand that I will be expected to meet certain requirements. The following are a minimum, but not limited to: attend and obtain certification in a Squad approved first aid class and CPR, attend a certified emergency vehicle operations class, participate in the night crew program and fundraisers. If accepted as a member, I will begin a period of probation not to last less than one full year from the time of acceptance. I understand that any equipment or apparel given to me by the Squad will remain Squad property. In addition, I understand that if my membership is terminated, either voluntarily or involuntarily, all property must be returned to the Squad. If the equipment is not returned, the Squad reserves the right to reclaim the property or its equivalent monetary value by all legal means available.

The above information is true to the best of my knowledge. I give the Atlantic Highlands First Aid & Safety Squad permission to conduct a background investigation in accordance with the guidelines set forth in the borough ordinance concerning volunteers.

I understand that should any of the information be false or should any cineraria of the background investigation not meet Squad requirements, I will subject myself to immediate expulsion from the organization, will be held responsible for any fees incurred for the background investigation and possible legal action.

Signature of Applicant:	Date:

APPLICATION MUST BE NOTARIZED AND PHYSICAL EXAM COMPLETED BEFORE ACCEPTANCE.

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Physical Form

To be completed by a practicing physician in the state of New Jersey.

Applicant Information	
Name:	
Date of Birth:	Height:
Eyesight:	Hearing:
Blood Pressure: /	

Does the applicant have any disabilities in:	
Heart:	Lungs:
Joints:	Veins:
Feet/Legs:	Hands/Arms:
Spine:	Hernia:

Has the applicant ever suffered from dizziness or fainting spells? Yes No
If yes, describe:
Has the applicant ever suffered from any injury? Yes No
If yes, give date & describe:
Use of narcotics? Yes No
If yes, please explain:
Remarks:

I hereby certify that as a practicing physician in the State of New Jersey, the applicant is physically (initial one):

Fit	Temporarily Rejected	Rejected

Temporary rejection or direct rejection based on the following:

Date Examined:	Examination location:

Signature of Physician:	Date:

Signed physical must accompany application to be turned into the Squad.