



# Cortlandt Community Volunteer Ambulance Corps

6 Kings Ferry Road, Box 275  
Montrose, NY 10548  
914 739 0881 914 739 8573

## Membership Application

Membership status requested      Riding \_\_\_\_\_ Associate \_\_\_\_\_

### Applicant

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Email address \_\_\_\_\_

Home telephone \_\_\_\_\_ Cell \_\_\_\_\_

### Employment Information

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Mailing address (if different than above) \_\_\_\_\_

Email address \_\_\_\_\_

Contact \_\_\_\_\_ Telephone \_\_\_\_\_

### Professional Reference

Please list any current (or prior) volunteer or professional organizations to which you belong.

Organization \_\_\_\_\_ Length of Service \_\_\_\_\_

Contact Name/Telephone/Email \_\_\_\_\_

Organization \_\_\_\_\_ Length of Service \_\_\_\_\_

Contact Name/Telephone/Email \_\_\_\_\_

Organization \_\_\_\_\_ Length of Service \_\_\_\_\_

Contact Name/Telephone/Email \_\_\_\_\_

### References

Please list three references, unrelated to you, that have knowledge of your character.

#### Reference One

Name \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_ Zip code \_\_\_\_\_

Home Telephone/Cell/Email \_\_\_\_\_

#### Reference Two

Name \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_ Zip code \_\_\_\_\_

Home Telephone/Cell/Email \_\_\_\_\_



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#### Reference Three

Name \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_ Zip code \_\_\_\_\_

Home Telephone/Cell/Email \_\_\_\_\_

Are you acquainted with any current or former members of the Cortlandt Community Volunteer Ambulance Corps? If so, who?

\_\_\_\_\_

#### Training (Please attach a copy of your certifications to this application.)

Are you currently certified as an EMT? \_\_\_\_\_ Expiration date \_\_\_\_\_

Are you currently certified in CPR? \_\_\_\_\_ Expiration date \_\_\_\_\_

Are you currently certified in first aid? \_\_\_\_\_ Expiration date \_\_\_\_\_

Other training (please specify) \_\_\_\_\_

#### Medical Information

Physician \_\_\_\_\_

Telephone \_\_\_\_\_

Medications \_\_\_\_\_

Do you have any medical/physical conditions that would affect you in case of an emergency or in any function as an emergency responder (i.e. heart condition, back problems, etc.)? If so, please explain:

\_\_\_\_\_

#### Personal Information

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Driver's License State/ID Number/Expiration \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_

If yes, please specify \_\_\_\_\_

\_\_\_\_\_

#### Signature

*"I attest and affirm, under the penalties of perjury, that the above information is accurate and complete. I agree to sign any consent form required by the Cortlandt Community Volunteer Ambulance Corps to perform necessary background checks."*

By submitting this application, I agree to the above statement.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_