

# Riggins Ambulance

## Application for Membership

Position for which you are applying: (Circle one) **EMT** **Driver** **Other** \_\_\_\_\_

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ SSN: \_\_\_\_\_

Residential Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address if different than residential \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Driver License # and State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Birth Date DD/MM/YYYY \_\_\_\_\_

# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
National Registry Certificate Number (if applicable) Expiration Date CPR Expiration Date

What other Emergency Services have you served with? (Please include dates & duties) \_\_\_\_\_

(If additional space is needed, use additional paper)

List three personal references and phone numbers (no family members please):

- 1) \_\_\_\_\_ Phone: \_\_\_\_\_
- 2) \_\_\_\_\_ Phone: \_\_\_\_\_
- 3) \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any medical condition that could affect your participation in emergency medical operations? **Y / N**

Whom should be notified incase of an emergency:

Name	Address	Phone #	Relationship
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- I hereby apply to volunteer with Riggins EMS as a volunteer member of the City of Riggins Ambulance. I agree to abide by its' Bylaws, SOP's and Idaho EMS Protocols. I authorize the Idaho County Sheriff to conduct a background and drivers license record check. (Initial here \_\_\_\_\_)
- I agree to serve with Riggins EMS as a member of City of Riggins Ambulance for a period of 2 years (24 months) beginning with the start date of my hepatitis immunization series if the City of Riggins pays for my immunizations. If I do not complete this 2 year agreement, I agree to reimburse City of Riggins for the costs associated with the immunization series. (Initial here \_\_\_\_\_)
- EMT'S ONLY: I agree to serve with Riggins EMS as an EMT for a period of 2 years (24 months) if the City of Riggins pays for my EMT training less the \$100.00 that I must pay which is reimbursed to me half on my first anniversary and the second half on my second anniversary. (Initial here \_\_\_\_\_)

All information contained within this application is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Information contained here-in is protected by the Privacy Act of 1974 (as amended).