# SEA ISLE AMBULANCE CORPS

**PO BOX 194**
**201 JFK BLVD**
**SEA ISLE CITY, NJ 08243**

| APPLICANT INFORMATION | | |
|---|---|---|
| Name: | | |
| Current address: | | |
| City: | State: | ZIP: |
| Home Phone: | Cell Phone: | |
| Date of Birth: | SSN: | |
| Email Address: | | |

| EXPERINCE: |
|---|
| **Have you ever been a member of any other emergency service, branch of military, or law enforcement organization?** ☐ Yes ☐ No |
| **If yes, please list below with dates, your reason for leaving, any offices held, and a reference name & number. (Attach additional sheets if needed)** |
| |
| |
| |

| CERTIFICATIONS: | | | |
|---|---|---|---|
| **Complete information for all that applies below:** | | | |
| **CPR** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **First Responder** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **NJ EMT-B** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **NJ EMT-P** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **NREMT-B** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **NREMT-P** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **CEVO (Or Equivalent)** | ☐ Yes ☐ No | **Cert #:** | **Date of expiration:** |
| **List any additional training or certifications you feel may be valuable below:** | | | |
| | | | |
| | | | |

# SEA ISLE AMBULANCE CORPS

**PO BOX 194**
**201 JFK BLVD**
**SEA ISLE CITY, NJ 08243**

| BACKGROUND INFORMATION | |
|---|---|
| Do you currently posses a valid NJ Driver's License?: | |
| If yes, DL #: | Expiration Date: |
| Has your driver's license even been suspended or revoked in this or any other state? | ☐ Yes ☐ No |
| If yes, please explain: | |
| | |
| Have you been involved in a motor vehicle accident within the last three years? | ☐ Yes ☐ No |
| If yes, please explain: | |
| | |
| Do you currently have any points on your driving record? | ☐ Yes ☐ No |
| If yes, please explain: | |
| | |

| MEDICAL INFORMATION | | |
|---|---|---|
| Do you have any problems with the following? (Please check all that apply) | | |
| ☐ Heart | ☐ Eyes | ☐ Fainting |
| ☐ Kidneys | ☐ Hearing | ☐ Diabetes |
| ☐ Lungs | ☐ Blood Pressure | ☐ Depression |
| ☐ Substance Abuse | ☐ Other | |
| Do you have any physical limitations? ☐ Yes ☐ No | | |
| If yes, please explain: | | |
| | | |
| Are you currently taking any medication regularly? ☐ Yes ☐ No | | |
| If yes, please list medications: | | |
| | | |
| If requested, would you consent to a physical examination by a doctor? ☐ Yes ☐ No | | |

## EMPLOYMENT HISTORY

**(LAST 4 YEARS, WITH MOST RECENT FIRST)**

# SEA ISLE AMBULANCE CORPS

**PO BOX 194**
**201 JFK BLVD**
**SEA ISLE CITY, NJ 08243**

| JOB 1: | | | |
|---|---|---|---|
| Company: | | | |
| Address: | | | |
| Phone Number: | | Dates of Employment: | |
| Job Title: | | Supervisor: | |
| **JOB 2:** | | | |
| Company: | | | |
| Address: | | | |
| Phone Number: | | Dates of Employment: | |
| Job Title: | | Supervisor: | |
| **JOB 3:** | | | |
| Company: | | | |
| Address: | | | |
| Phone Number: | | Dates of Employment: | |
| Job Title: | | Supervisor: | |

## REFERENCES

Please provide two (2) business references and one (1) personal reference.

| BUSINESS REFERENCE #1: | | | |
|---|---|---|---|
| Name: | | Title: | |
| Address: | | | |
| Phone Number: | | Email: | |
| **BUSINESS REFERENCE #2:** | | | |
| Name: | | Title: | |
| Address: | | | |
| Phone Number: | | Email: | |
| **PERSONAL REFERENCE #1:** | | | |
| Name: | | Title: | |
| Address: | | | |
| Phone Number: | | Email: | |
| **PERSONAL REFERENCE #1:** | | | |
| Name: | | Title: | |
| Address: | | | |
| Phone Number: | | Email: | |

Please specify which level of membership you are seeking below. (Check the appropriate box)


# SEA ISLE AMBULANCE CORPS

**PO BOX 194**
**201 JFK BLVD**
**SEA ISLE CITY, NJ 08243**

| | |
|---|---|
| ☐ Active Membership: | Active members are at least CPR and First Aid certified, and respond on a rotation or as-available basis to medical emergencies. Active members are eligible to vote on squad business and to hold administrative or operational office. |
| ☐ Associate Membership: | Associate members are available to provide necessary services to the Squad, but do not routinely respond to medical emergencies. Associate members may attend squad meetings and functions, and may hold administrative offices, but may not vote on Squad business nor hold operational offices. |

Incomplete applications will delay consideration for membership. When submitting, please be sure to include:
--Complete Application in its entirety.
--Copy of your driver's license, CPR card, and EMT certification (if applicable)/
--Any additional certifications.

## APPLICANT DECLARATION

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that any false statement, omission or misrepresentation on this application is sufficient cause for refusal or dismissal of membership, no matter when discovered by the Sea Isle Ambulance Corps. **Initial: ____**

Further, I authorize the Sea Isle Ambulance Corps and/or the City of Sea Isle to perform a background investigation and I authorize my employer and references to disclose information regarding my employment, character, and general reputation to the Sea Isle Ambulance Corps, without giving me prior notice of such disclosure. In addition, I release the Sea Isle Ambulance Corps, Employer(s), and all references from any claims, demands or liabilities arising from any investigation or disclosure. **Initial:____**

I authorize the Sea Isle Ambulance Corps and/or the City of Sea Isle to check the status of my driver's license at any time the Sea Ambulance Corps deems necessary. I also authorize the Sea Isle Ambulance Corps to release my driver's license number to the applicable Insurance Company(s). Initial:____

I authorize the release of my name, address and contact information to the Sea Isle Ambulance Corps members, and any other person(s) that the Sea Isle Ambulance Corps may utilize to help in considering your application for membership. Initial.

**SIGNATURE OF APPLICATION:_____DATE: _____**