

# Old Bridge First Aid & Rescue Squad, Inc



## MEMBERSHIP APPLICATION

Application Type: Regular Junior Reserve Life Associate

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Religion: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Drivers License # \_\_\_\_\_

Referred by: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Do you have any physical or mental conditions that may prevent you from performing EMS duties?

No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes please explain below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any experience in the emergency medical field?

No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes please explain below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree to accept and fulfill the requirements and rules of the Old Bridge First Aid & Rescue Squad. I also agree to take the required emergency medical training, in a timely period allotted. I agree to accept the insurance provided by the Old Bridge First Aid & Rescue Squad. I also agree to take responsibility for all equipment and uniforms issued to me. Furthermore, I attest that the information provided by me is true and factual. Any misrepresentations will result in immediate termination from the Old Bridge First Aid & Rescue Squad.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SQUAD USE ONLY

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Date Accepted \_\_\_\_\_ Date Resigned \_\_\_\_\_ Date Removed \_\_\_\_\_

Reason for removal: \_\_\_\_\_

The following are requirements for membership of the Old Bridge First Aid & Rescue Squad.

#### Training:

- Cardiopulmonary Resuscitation (CPR Health Care Provider w/ Defib)
- NJ or National Registry Emergency Medical Technician (EMT)
- ICS 100 and ICS 200
- NIMS 700 and NIMS 800
- Hazardous Materials Awareness level or greater
- Blood borne Pathogens Awareness
- Right to know training
- Members wishing to drive squad vehicles must be at least 18 years old, completed a CEVO ambulance course and participate in our in-house drivers training program.
- All members are required to enroll in the above listed class within one year of joining.

#### Duty Schedule

- Regular members must be available for first aid duty at least one evening per week from 1800 to 0600 hours (12 hours). Regular members are also responsible for one duty weekend every 5 weeks from Saturday 0600 hrs to Monday 0600 hrs (48 hours total).
- Junior members must be available for first aid duty at least one evening per week from 1800 to 2200 hours (4 hours). Junior members are also responsible for one duty weekend every 5 weeks in which they must complete 13 hours. The times of these hours will be determined by the Officer In-Charge.
- All members must be available for additional duties and assignments as posted by the Captain or President.
- All members must complete the required house duties as specified by the Officer In-Charge, President, or Captain.

#### Meetings

- Attendance is required for all members at the monthly squad business meeting. This meeting is held on the third Sunday of each month beginning at 1900 hrs unless otherwise specified.
- Attendance is required for all members at any special meeting posted as by the.

#### Committees

- All members must participate in at least one committee as posted by the President
- All members must attend at least 1 coin toss per year.

#### Issued Equipment

- Each member will be issued squad equipment at no cost to them.
- Members are responsible for cleaning and care of all issued equipment.
- Any damaged equipment must be reported as soon as possible to the Officer In-charge.
- If a member decides to resign from the squad or is removed, all issued equipment must be returned within 7 days. After 7 days all attempts will be made by our squad to get issued equipment which may include notification to law enforcement.
- No squad uniform, insignia or name shall be worn outside the squad by any member that is not a certified EMT.
- ID cards remain property of the squad and must be turned in upon leaving the squad.

Generally

- Workers Compensation and/or Life Insurance will be provided by the squad or the Township of Old Bridge.
- A LOSAP will be provided by the squad or the Township of Old Bridge he/she is responsible for maintaining it.
- Each member must have a telephone (landline or cellular)
- Each member must participate in fund raising activities.
- Each member must reside within Middlesex County, NJ and be within 7 minutes of the squad while on duty.

Each member will

- Be on probation for 6 months or until all training is completed. (Whichever is greater)
- Have no voting privileges till off probation.

If necessary probationary members will be removed as members of the Old Bridge First Aid & Rescue Squad without a hearing or notice for any violation of the squad by-laws, rules, or regulations.

I do hereby acknowledge that I have read and fully understand all of the above information and statements.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Criminal Background Questionnaire**

Have you ever been arrested?

No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes please explain below. Date, location, and offense)

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a crime?

No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes please explain below)

\_\_\_\_\_  
\_\_\_\_\_

**Background Authorization Release**

I \_\_\_\_\_, am here by giving the Old Bridge First Aid & Rescue Squad the authorization to perform a criminal background check at any time. By signing below, I understand that any crime committed in my past may call for immediate termination of my membership of the squad. I also understand that any misconduct may result in immediate termination from the squad.

I have read and agree with the statements above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Squad Uniform & Equipment Check List

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pager #: \_\_\_\_\_ Base #: \_\_\_\_\_

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### Jacket

Size: \_\_\_\_\_ Liner: \_\_\_\_\_ Number: \_\_\_\_\_

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### Uniforms

Polo: \_\_\_\_\_ Sweat Shirt: \_\_\_\_\_ White Button Down: \_\_\_\_\_

T-Shirt: \_\_\_\_\_ Coveralls: \_\_\_\_\_ Blue Button Down: \_\_\_\_\_

Pants: \_\_\_\_\_ Tie: \_\_\_\_\_ ID card: \_\_\_\_\_

Vehicle Placard: \_\_\_\_\_ Badge: \_\_\_\_\_ Decal: \_\_\_\_\_

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I agree upon my leaving of the Old Bridge First Aid & Rescue Squad that I will return all issued equipment within 7 days in good clean condition. Any destroyed/damaged or lost items will be my responsibility and payment for these items must be made with 14 business days.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Issuing Officer: \_\_\_\_\_ Date: \_\_\_\_\_

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Returned items and Notes:

## INSURANCE INFORMATION

Sex  M  
 F

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Last                  First                  Middle                  Birthdate**

**YOUR SOCIAL SECURITY NUMBER**    -   -

**STATE OF RESIDENCY** \_\_\_\_\_

**BENEFICIARY (S) NAME (S) (Fill in only when Death Benefits are provided):**

★	First	M.I.	Last	Relationship	D.O.B.
( )					/ /
( )					/ /

★ Multiple beneficiaries will be considered equal unless designated as:  
 Primary (1) or Secondary (2):

★ **DEPENDENT STATUS (Fill in only when Dependent Benefits are provided):**

Are you married?  YES Spouse's Sex of  M  
 NO Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse  F

Spouse  is  is not insured for Group Health Benefits where employed?

Do you have eligible children? (see plan details)  NONE  ONE  TWO OR MORE

Do you want the above dependents insured?  YES  NO

Youngest child's birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Supplemental Life Insurance  YES  NO If yes, amount: \$ \_\_\_\_\_

I hereby request the insurance to which I am or may become entitled under the Group Policy(ies) issued by the Company and authorize deductions, if any, from my earnings towards the cost of the insurance. I understand that I must work a minimum of 30 hours per week in order to be eligible. (Sign below)

I do not wish to be insured (Sign below)

★ **Date Signed** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Signature of Applicant** \_\_\_\_\_

**Date Signed** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Parent or Guardian** \_\_\_\_\_

LIFE INSURANCE COMPANY OF NORTH AMERICA  
 INSURANCE COMPANY OF NORTH AMERICA

EMPLOYER COMPLETE

~~Policy No. \_\_\_\_\_~~

~~Name of Employer: \_\_\_\_\_~~

~~Applicant Employed \_\_\_\_\_~~

Month      Day      Year

~~Applicant Entered Eligible Class (if later than above):~~

\_\_\_\_/\_\_\_\_/\_\_\_\_

~~Occupation: \_\_\_\_\_~~

Hourly     Salaried

~~Average Annual Salary \_\_\_\_\_~~

CO USE

~~\_\_\_\_/\_\_\_\_/\_\_\_\_~~

E# Date of Iss

~~Class Code \_\_\_\_\_~~

LM-6855e

ENROLLMENT FORM INSURANCE COMPANY COPY

# “HEPATITIS B IMMUNIZATION”

## WAIVER FORM

By signing below you have declined to receive from the Township of Old Bridge and the Old Bridge First Aid and Rescue Squad Inc., at no cost to yourself the Hepatitis B immunization.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease.

If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_