New Hartford Volunteer Ambulance

P.O. Box 1, New Hartford, CT 06057

Phone: (860) 379-6060

www.NHVAAmb.org

MEMBERSHIP APPLICATION

First Name: ____

Last Name: ____

Date of Birth: _____/______/______

Address: ____

____

Home Phone: (______) _______________-_________________

Work/Cell Phone: (______) _______________-_________________

E-Mail Address: ______________________________________@___________________________________

Do you have any prior EMS experience? YES NO

Name of Service: ____

Address: ____

____

Phone: (______) _________________-_____________________

Date Started: ______/______ Date Ended: ______/______

Please List Any Related Certifications (CPR/MRT/EMT/ICS and include Expiration Dates and Numbers):

____

____

____

Any Other Information You Feel Important:

____

____

I certify that to the best of my knowledge, the information provided on this application is true, and I understand that any intentional misrepresentation of this information could lead to my dismissal. By submitting this application, I authorize the New Hartford Volunteer Ambulance Association to make an investigation of my history and verify my qualifications for membership. I also release from all liability of responsibility all persons and organizations supplying information.

Signature: ____ Date: __________