Allendale Ambulance Corps, Inc.
26 Arcadia Road
Allendale, New Jersey 07401-2002
www.allendaleambulance.org

Application Received: _____
Application Reviewed: _____
Application Accepted: _____

Member Application

Name _____ Date _____
Address _____
Phone number _____ (home) _____ (cell)
Email _____ Date of birth _____
U.S. Citizen? Yes / No (circle one) Place of Birth _____
Occupation _____ Social Security #_____
Place of Employment _____ Work phone _____
N.J. Driver's License # _____ # years driving _____
Has your license ever been suspended? Yes _____ No _____ Points on license _____
Have you ever held any of the following certifications?

Course	Expiration Date	Course	Expiration Date
EMT		EMR (First Responder)	
CPR		Bloodborne Pathogens	
CEVO		Hazardous Materials	

Please include copies of any certifications with your application

AVAILAILITY – please check below the days and times that you are available

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning (6:00AM – 12:00PM)							
Afternoon (12:00PM – 6:00PM)							
Evening (6:00PM – 11:00PM)							
Overnight (11:00PM – 6:00AM)							

Who recommended you to the corps? _____
List name, address & phone of 2 people we may contact as references:
Name: _____ City/State: _____ Phone: _____
Name: _____ City/State: _____ Phone: _____
Have you ever been convicted for violation of any law or ordinance (including traffic Violations) or felony: Yes _____ No _____ if yes, please explain _____
_____

Applicant's Declaration
I certify that the information contained in this application is true to the best of my knowledge. It is understood that any false statement on this application is sufficient cause for rejection or dismissal. If acceptance is obtained under this application, I agree to submit to a physical examination and a driver's license / background check.

Signature _____ Date _____

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Physical Examination

To be completed by a Physician

Name _____ Date of Exam: _____
Address _____
Phone _____ (home) _____ (cell)

Section Below To Be Completed By a Physician

Current Conditions / Medical History
Allergies: _____
Medications: _____
Seizures or Syncope: _____
Heart Disease: _____
Back Disorders: _____
Previous Surgery: _____
Height: _____ Weight: _____ Blood Pressure: _____
Blood Type: _____ +/-
Vision: R _____ L _____ Corrective: Glasses / Contact Lens (*circle one*)

Vaccination History / Communicable Diseases

Have you had?	Yes	No	Unsure
Standard series of childhood vaccinations (to the best of your knowledge)?			
Chicken Pox or the Chicken Pox (Vericella) vaccine?			
A Tetanus/Diphtheria booster shot within the past 10 years?			
Hepatitis B vaccine (series of three injections spaced over several months)?			
Tuberculosis?			
A positive PPD Test (TB Test)?			
Date of last TB Test _____			

Notes: _____
_____

Please check one

I approve the above-named individual for EMS Service: ☐
I do NOT approve the named individual for EMS Service ☐
If no, please explain: _____
_____

Examining Physician Name: _____Date: _____
Examining Physician Signature: _____

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Permission Forms
Members – under 18 years only

Ambulance Duty Time

_____ has my permission to respond to ambulance calls between the hours of:

Weekdays during school*	YES	NO	*If permission is granted to respond during school hours - Please contact the school regarding required authorization
Weekdays between 2:30pm -11:00pm	YES	NO	
After 11:00pm, on school nights	YES	NO	
Weekends 6:00am – 6:00am	YES	NO	
Weekends 6:00am – 11:00pm	YES	NO	

Please circle which one(s) you will allow

If permission is granted to respond to calls during school hours, please contact the school to ascertain the authorization form that is required. I understand that the student is responsible for any work missed during his/her absence from school. I also understand that the student is expected to return to the school immediately following the completion of the call. The school has the discretion to deny response based upon specific activities or school work at the time of the call.

AVAC Member's Name (**please print**): _____

AVAC Member's Signature_____ Date: _____

Parent / Guardian Name (**please print**): _____

Parent / Guardian Signature_____ Date: _____

Ambulance Building Usage

_____ has my permission to be in the Allendale Ambulance Corps building. I understand that there are times when he/she may be there before/after a call and my not be under the supervision of an adult.

AVAC Member's Name (**please print**): _____

AVAC Member's Signature_____ Date: _____

Parent / Guardian Name (**please print**): _____

Parent / Guardian Signature_____ Date: _____

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PHOTO RELEASE

I _____, understand that the Allendale Ambulance Corps to utilize photographs as part of its recruitment/public information campaign. This may involve photos taken at drills meetings, on calls or at other ambulance corps functions. These photos maybe used in newspapers, brochures or posters. I can revoke this permission at any time by submitting a written revocation to the Captain or President of the Allendale Ambulance Corps.

If I am a minor, I have also obtained the consent of my parent or guardian who has signed and printed their name below

AVAC Member's Name (**please print**): _____

AVAC Member's Signature_____ Date: _____

Parent /Guardian Name (**please print**): _____

Parent /Guardian Signature_____ Date: _____

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IAmResponding Information Sheet

First Name: _____

Last Name: _____

Address: _____

Town: _____

State: _____

Zip Code: _____

Home Phone #: _____

Cell Phone #: _____ Cell Phone Carrier: _____

Work Phone #: _____

Personal Email: _____

AVAC Email: _____

_____

_____

Please print information above. Include any additional phone number that you likely use to call in to IAmResponding

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PLEASE COPY THE INFORMATIONBELOW OR TEAR OFF TO KEEP FOR YOUR RECORDS

Number to phone in for call response is ------- 800*301*9710

When a call is dispatched, please call 800*301*9710. You will hear an automated vice say, “Enter one (1) through nine (9). Enter one of the following response codes:

- ☆ 1 - AVAC
- ☆ 2 - WALVAC
- ☆ 3 - Scene
- ☆ 4 – AVAC / Delay
- ☆ 5 – WALVAC / Delay
- ☆ 6 – Scene / Delay
- ☆ 7 – Station
- ☆ 8 – Station
- ☆ 9 – Cancelled
- ☆ Default – station – if you don’t enter in a number the system will take the “Default” selection

You can also use the IAmResponding app on your smart phone to your response

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AVAC ID Card Information

Please print all information legibly

Name**:** _____

Position (circle one): **EMT** **Driver Lifter** **EMR**
Auxiliary **Associate Member** **Life Member**

Agency: **Allendale Ambulance Corps**

The following information will be encoded on the back of the card in a bar code:

Address: _____

City/Town**:** _____State: _____ Zip: _____

Emergency Contact Name**:** _____

Emergency Contact Phone #: _____

Gender: _____ DOB: _____

Height: _____

Eye Color: _____ Hair Color: _____

Driver's License #: _____

EMT Certificate # _____

Allergies:

Medications:

Medical History:

Member's signature: _____

Borough of Allendale
Authorization and Consent to Conduct a Criminal History Record Background Check

Policy: The Borough of Allendale desires to maintain the highest professional standards for the Borough's entire workforce and to ensure the safety of all of its employees, residents and citizens. N.J.S.A. 40:48-1.4 permits a municipality to require a criminal history record background check of any individual seeking employment with the Borough. This includes the members of the Allendale Volunteer Ambulance Corps and Allendale Fire Department. In accordance with the statute, a criminal history record background check shall be required of all prospective employees that are given a conditional offer of employment, including, but not limited to, permanent, provisional, temporary and seasonal employees, as part of a conditional offer of employment. All such prospective employees shall be required to pass the criminal history record background check as part of the confidential offer of employment.

I, _____, understand that as a part of a conditional offer of employment with the Borough, the Borough of Allendale will conduct a criminal history record background check to determine my suitability for the position for with I have applied and been given a conditional offer of employment pending a negative finding as to my criminal history record background check and any other requirements based on law/procedure.

I understand that, as a part of this process, I shall submit to being fingerprinted. I further understand and authorize the Borough; by it duly authorized representative, to exchange my fingerprint data with and receive criminal history record information from the State Bureau of Identification in the Division of State Police and the Federal Bureau of Investigation.

I understand that a negative criminal history record background check is a condition for employment with the Borough.

I understand that if I refuse to submit to fingerprinting or if I refuse to execute the within written Authorization and Consent to Conduct History Record Background Check form, I will be immediately rejected for employment and the conditional offer of employment shall be immediately withdrawn.

I understand that if my criminal history record background check reveals a record of conviction of any of the following crimes and offenses, I will be rejected for employment:

(a) In New Jersey, any crime or disorderly person's offense of petty disorderly person's offense:

(1) Involving danger to the person, including, but not limited to those crimes, disorderly offenses and petty disorderly persons offenses set forth in N.J.S.A. 2C:11-1 et. seq.; N.J.S.A. 2C:12-1 et. seq.; N.J.S.A. 2C:13-1 et. seq.; N.J.S.A. 2C:14-1 et. seq.; and/or N.J.S.A. 2C:15-1 et.seq.;

(2) Against the family, children or incompetents, including, but not limited to those crimes, disorderly person's offenses and petty disorderly offenses set forth in N.J.S.A. 2C:24-1 et.seq.

(3) Involving arson, burglary of theft as set forth in N.J.S.A. 2C:17-1 et. seq.; N.J.S.A. 2C:18-1 et. seq.; and/or N.J.S.A. 2C:20-1 et. seq.

(4) Involving offenses against public administration, perjury and other falsification of official matters, obstruction governmental operations, misconduct in office and/or abuse of the office as set forth in N.J.S.A. 2C:27-1 et. seq.; N.J.S.A. 2C:28-1 et. seq.; N.J.S.A. 2C:29-1 et. seq.; or N.J.S.A. 2C:30-1 et.seq.

(5) Involving any controlled dangerous substance or controlled substance analog as set forth in Chapter 35 of Title 2C of the New Jersey Statues; or,

(6) Involving operation of a motor vehicle while intoxicated in violation of Chapter 4 of Title 39 of the New Jersey Statutes.

(b) In any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes, disorderly persons or petty disorderly person's offenses described herein.

I have read and understand the information contained on the "Authorization and Consent to Conduct a Criminal History Record Background Check" form. I agree to submit to a criminal history record background check as part of the pre-employment/employment process

_____ _____

Applicant Signature Date

_____

Witness

NJMVC
New Jersey Motor Vehicle Commission
Business Licensing Services Bureau
P.O. Box 170
Trenton, NJ 08666-0160
609-292-6500 ext. 5094
609-292-4400

APPLICATION FOR MUNICIPAL EMERGENCY BLUE WARNING LIGHTS VOLUNTEER OFFICE OF EMERGENCY MANAGEMENT

Date: _____

I hereby apply for a permit authorizing the installation and use of emergency blue warning lights.

(PLEASE PRINT)

Name: _____ Address: _____

City: _____ County: _____ Zip Code: _____

E-mail Address: _____ Telephone #: _____

_____ _____
Volunteer's Signature NJ Driver License Number

_____ _____
Signature of Chief/Captain of Volunteer Organization Organization's Name in Full

_____
Organization's Corp Code

Please check: ☐ Paid Employee ☐ Volunteer

☐ Initial ☐ Renewal ☐ Duplicate Permit No. _____

This section is to be completed by the **Mayor or the Chief Executive Officer of the governing body of the municipality being served by the volunteer fire department, first aid or rescue squad or OEM volunteer**.

I _____ have read the information pertaining to the issuance of this application for a blue light and believe the applicant qualifies for a permit.
Please Print

Signature: _____

Title: _____

Governing Body: _____

Address: _____

City, County and Zip Code: _____

NJMVC EIN: _____

Telephone #: _____

E-mail: _____

New Jersey Motor Vehicle Commission
Business Licensing Services Bureau
P.O. Box 170
Trenton, NJ 08666-0160
609-292-6500 ext. 5094
609-292-4400

INFORMATION PERTAINING TO BLUE EMERGENCY WARNING LIGHT REGULATIONS

ELIGIBILITY:
An applicant for a permit authorizing the use of emergency blue warning lights pursuant to N.J.A.C. 13:24 et seq., may be considered eligible only if the applicant is an active member in good standing of a volunteer fire company, first aid or rescue squad, or a county or municipal Office of Emergency Management volunteer whose official duties include responding to a fire or emergency call.

POSSESSION AND EXHIBITION OF PERMIT:
The permit must be in the possession of the operator at all times when the blue light(s) are operated on the vehicle and must be exhibited upon the request of any law enforcement official.

PERMIT VALIDITY, CANCELLATION, REVOCATION:
Permits are valid for four (4) years from the date of issuance and are non-transferable. When a person to whom a permit is issued ceases to be an active member in good standing of a volunteer fire company, volunteer first aid or rescue squad, or a volunteer Office of Emergency Management, the permit must be surrendered. Permits must be surrendered to the Motor Vehicle Commission within ten (10) days of the date of cancellation or revocation.

MOUNTING OF LIGHTS:
Emergency warning lights shall be removable or permanently attached of the flashing or revolving type, equipped with a blue lens and controlled by a switch installed inside the vehicle, or shall be blue of the light bar type. No more than two emergency warning lights shall be installed on a vehicle. If one light is used it shall be installed in the center of the roof of the vehicle, or on the front of the vehicle so that the top of the emergency warning light is no higher than the top of the vehicles headlights, or in the center of the dashboard. It may be a low-profile light bar of the strobe, halogen, or incandescent type, or a combination thereof. If two lights are used they may be placed on the windshield columns on each side of the vehicle where spotlights are normally mounted, or on either side of the roof at the front of the vehicle directly back of the top of the windshield. Under no circumstances may one light be placed on the roof and one on the windshield column in the spotlight position. Light elements shall be shielded from direct sight of view of the driver.

ALTERNATING FLASHING OR STROBE HEADLIGHTS ARE PROHIBITED AND SHALL NOT BE INCORPORATED INTO THE HOUSING OF ANY LIGHTING.

USE:
The emergency blue warning lights may be used only when the vehicle is being operated in response to an emergency. Any other use of the light is prohibited.

Questions related to the application for an emergency blue warning light may be directed to the Business Licensing Services Bureau at (609) 292-6500 ext. 5014.

FIRST REPONDER / / HOUSEHOLD MEMBER INFORMATION FORM

General Completion Guidelines:

- A ”Household” includes all persons who occupy a housing unit (house, apartment, etc.) U.S. Census
- Please fill in the Name and Address of your First Responder Agency
- Also complete the information requested in the ‘First Responder’ Agency
- If your agency has agreed to an alternate means of identification for you (such as badge number, ID#, etc.),follow that direction
- Return the completed form (immediately or as instructed) to the agency representative designated to collect them

If you participate as first responder with more than one agency:

- It is necessary to fill out only one form per household
- Identify the agency for which you would have the highest level of response commitment and complete the form for that agency (For example: if you volunteer for a fire or EMS service in the town where you live as well as nearby town, you may want to complete the form for that agency in your town; OR if you are employed as a first responder and also volunteer, your employer would expect you to report the duty, therefore complete the form for the employer)

Medications:

- Ciprofloxacin (Cipro) and Doxycycline (Doxy) are antibiotic medications used to combat infection from certain bacteriological diseases and /or biological agents (e.g. anthrax, plague, and tularemia) that maybe used as weapons in a bioterrorism attack.
- These medications can be used a prophylaxis (taken prior to or post exposure) that may reduce the effects of the disease, or prevent the disease from developing in those that may have been exposed
- Further information about use, contraindications and possible reaction to each of these medications have been supplied to your agency as a “Patient information Sheet” for each medication. If you or members of your house hold have known allergies to any medications, please refer to additional information of these sheets.
- Remember: these medications will only be issued in serious, wide-spread public health emergencies, in order to protect against life-threatening diseases / biological agents.

Column 1:

- List you name and the names of your household members
- If you agency has agreed to an alternate means of identification for you (the responder) or your household members, follow that direction (such as badge number, child 1, child 2, etc.)

Column 2:

- If you have **no** allergies to either Cipro or Doxy; if you have **no** conditions that might lead to adverse reactions for taking either Cipro or Doxy; if you have **no other contraindications** to either medication; enter “YES” in this column

Column 3:

- If you can take **ONLY** Cipro, meaning that you have one or more contraindications (including allergies or adverse reactions) **and cannot take Doxy**; enter “YES” in this column

Column 4:

- If you can take **ONLY** Doxy, meaning that you have one or more contraindications (including allergies or adverse reactions) **and cannot take Cipro**; enter “YES” in this column

Column 5:

- If you **cannot take Cipro or Doxy** because of allergies, medical conditions or other contraindications; enter “YES” in this column. In the event of a wide-spread public health emergency, further guidance will be given to these individuals regarding precautions and treatment.

FIRST RESPONDER - HOUSEHOLD MEMBER INFORMATION FORM

First Responder Agency: Allendale Volunteer Ambulance Corps Address: 26 Arcadia Road Allendale, New Jersey 07401

First Responder Last Name: _____ First Name: _____ MI: _____

Home Address _____ City _____ State _____ Zip _____

Phone # Home: _____ Work: _____ Cell: _____ Email: _____

For further assistance completing this form please refer to guidelines on the reverse side. This form is intended for use by the First Responder Agency listed above to assist in the rapid distribution of prophylactic medication that will be made available to you and your immediate household members in the event of a bioterrorism attack (e.g. anthrax) or a large-scale public health emergency. **Please Print**

1	2	3	4	5
Names of responders and all household members	Can take **BOTH** Ciprofloxacin and Doxycycline	Can take **ONLY** Ciprofloxacin	Can take **ONLY** Doxycycline	Can take **NEITHER** Ciprofloxacin and Doxycycline
TOTALS				

Please place the word '**YES**' in which ever column best describes each individual's medication status. If you are unsure if you can safely take either one or both of these antibiotic Medications, please consult the guidance on the reverse of this form, other attached documents, or consult your physician.

First Responder Signature: _____ Date Completed: _____ Date(s) Reviewed: _____