Wolcott Volunteer Ambulance Explorer Post 2166

Application

Wolcott Volunteer Ambulance Explorer Post 2166

Prospective Explorer,

Thank you for your interest in Wolcott Volunteer Ambulance Explorer Post 2166. As an explorer with Wolcott Volunteer Ambulance Association, your role is vital. As an explorer you will receive all the proper training that would be needed to perform with our EMTs and Paramedics. This program is designed to help young adults between the ages of 14 - 21 decide if they will enjoy working in the medical field.

Please fill out the attached application in its entirety. All of the information that you provide will be kept confidential and will not be released to any third party organizations. You will need to sign a few places in the application. If you are under 18 years old, a parent or legal guardian will need to sign as well. Please attach any related certifications you may have for our records. Upon receiving the application, an interview will be conducted by our personnel committee. They will ask a series of questions to get to know you. Once the interview is complete, the personnel committee will bring the application to the attention of the general membership where they will vote on your acceptance. You will be notified by an advisor after the next meeting is conducted.

Your application will be viewed when we receive it and we will get back to you within a week. All applications can be dropped off at our headquarters located at 48 Todd Rd, Wolcott, CT or mailed in. The Mailing address is:

Wolcott Vol. Ambulance Assoc.
Attn. Explorer Post 2166
P.O. Box 6066
Wolcott, CT 06716

We look forward to working with you. Please feel free to call or email our Lead Advisor for more information. Thank you for your interest in our post.

Sincerely,

Jayson Braman
Lieutenant / Lead Advisor
Wolcott Vol. Ambulance Assoc.
(203)-879-4122 EXT. 120
jay.braman@wolcottambulance.com

Please Detach and Retain
General Requirements for Membership

- Applicant must be between the ages of 14 to 21
- Applicant must complete and sign the explorer application *(if under the age of 18 a parent or legal guardian must also sign)*
- Applicant must complete an interview with the personnel committee
- Upon receiving the proper training the applicant must complete a minimum of eight hours of ride time per yearly quarter
- Town of Wolcott residency is not required
- Explorers must follow and abide by all of the Explorer by-laws
- Applicant must be in good academic standing with a 70% or higher GPA
- All applicants subject to a background check

WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION
EXPLORER POST #2166

Application for Membership

PLEASE PRINT ALL INFORMATION ON THIS FORM

NAME: _____
First Name Middle Initial Last Name

ADDRESS: _____

TOWN: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____

SCHOOL: _____ GRADE: _____

PARENTAL / GUARDIAN INFORMATION:

NAME: _____
First Name Middle Initial Last Name Relationship

NAME: _____
First Name Middle Initial Last Name Relationship

DRIVERS LICENSE INFORMATION:

DO YOU CURRENTLY HAVE A DRIVERS LICENSE: YES ☐ / NO ☐

IF YES, OPERATORS NUMBER: _____ TYPE: _____

IS SOMEONE IN YOUR "IMMEDIATE FAMILY" AN ACTIVE MEMBER OF THE WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION: YES ☐ / NO ☐

NAME OF RELATIVE: _____ RELATIONSHIP: _____

PHYSICAL CONDITIONS:

DO YOU or ARE YOU SUBJECT TO:

ASTHMA:	YES ☐ / NO ☐	DIABETES:	YES ☐ / NO ☐
HEART PROBLEMS:	YES ☐ / NO ☐	FAINTING SPELLS:	YES☐ / NO ☐
CONVULSIONS:	YES ☐ / NO ☐	BLEEDING DISORDERS:	YES ☐ / NO ☐
ALLERGIES:	YES ☐ / NO ☐		

Identify Allergies: _____

ANY CONDITION REQUIRING SPECIAL CARE: YES ☐ / NO ☐

Identify Condition: _____

ANY SPECIAL MEDICATION REQUIRED FOR ILLNESS OR ALLERGY YES ☐ / NO ☐

Identify Medication: _____

ANY RESTRICTION OF ACTIVITY FOR MEDICAL REASONS: YES ☐ / NO ☐

Identify Medical Reason: _____

PARENT / GUARDIAN PLEASE READ: (please explain this section to your child)

By virtue of your signature below you are stating that the information provided in this application is true, furthermore by your signature below you are also in full agreement with the terms and conditions contained within the "STATEMENT OF POLICY FOR EXPLORER POST #2166", also by your signature you have identified that you will live up to your obligation as a parent / guardian of a WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER. Your child will need to perform the following: provide a recent (within last 6 months) medical physical identifying your child's health, this document must be signed by your child's physician, and/or will under-go a physical by the physician for the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION. (Information is available upon request) A copy of your child's birth certificate must accompany this application. The submission of this application does not necessarily indicate membership in the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166. Your child will be notified by an advisor or a member of explorer membership committee as to the disposition of the application. Your child may be contacted by the explorer membership committee for an interview only after the candidate's application is accepted.

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____

APPLICANTS SIGNATURE: _____ DATE: _____

DO NOT WRITE BELOW THIS LINE

Interview date: _____ **Acceptance date:** _____ **Rejection date:** _____

Membership committee members present:

_____

I _____ have personally appeared before the membership committee for the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166, and here-by testify that I am fully acquainted with the duties of an active member of the aforementioned ambulance association and here-by accept and will perform them to the best of my abilities.

SIGNATURE OF APPLICANT: _____

WAIVER FOR PARTICIPATION IN
WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166.

IN CONSIDERATION OF YOU ACCEPTING MY CHILD'S APPLICATION FOR MEMBERSHIP AND ENTRY;

I HEREBY FOR MYSELF, MY CHILD, MY HEIRS, EXECUTORS AND ADMINISTRATORS, WAIVE AND RELEASE ANY AND ALL RIGHTS AND CLAIMS FOR DAMAGES I OR MY CHILD MAY HAVE AGAINST THE TOWN OF WOLCOTT OR THE WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION AND ITS REPRESENTATIVES, SUCCESSORS AND ASSIGNS, FOR ANY AND ALL INJURIES SUFFERED BY MYSELF OR MY CHILD AT ANY ACTIVITY SPONSORED BY THESE GROUPS.

NOTE: This waiver must be signed in order for the candidate's application to be accepted by the membership committee.

PARENT / GUARDIAN SIGNATURE: _____

DATE: _____

ADVISORS SIGNATURE: _____

DATE RECEIVED: _____

CHIEF OF ASSOCIATION: _____

DATE: _____

WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION
EXPLORER POST #2166.

EMERGENCY NOTIFICATION AND TREATMENT CONSENT FORM

PLEASE TYPE / PRINT ALL INFORMATION

DEAR PARENT / GUARDIAN;

IF THERE EVER SHOULD BE A SITUATION WHERE YOUR SON *I* DAUGHTER SHOULD BECOME ILL OR INJURED WHIILE UNDER THE DIRECTION OF THE WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION WE NEED TO HAVE THIS INFORMATION ON FILE. THIS INFORMATION WOULD ALLOW US TO CONTACT YOU DURING AN EMERGENCY. ALSO IF WE WERE UNABLE TO CONTACT YOU, WE WOULD BE ABLE TO CONTACT THE PERSON/S IDENTIFIED ON THIS FORM.

WILL YOU PLEASE FILL OUT THE BLANK FORM BELOW AND RETURN IT AT THE NEXT MEETING.

IF THERE IS A CHANGE IN ANY OF THIS INFORMATION PLEASE NOTIFY US IMMEDIATELY. WE WILL REQUIRE YOU TO PROVIDE UPDATES AS INFORMATION CHANGES OCCUR.

MEMBER'S NAME: _____
First Name Middle Initial Last Name

PARENTAL / GUARDIAN INFORMATION:

NAME: _____
First Name Middle Initial Last Name Relationship

HOME PHONE: _____ WORK PHONE: _____

WORK ADDRESS: _____ YES ☐ / NO ☐

NAME: _____
First Name Middle Initial Last Name Relationship

HOME PHONE: _____ WORK PHONE: _____

WORK ADDRESS: _____

PHYSICIANS NAME: _____

PHYSICIANS PHONE: _____

IF WE CAN NOT CONTACT YOU, WHO SHOULD WE CALL?

NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

IMPORTANT!!!!!!!!!

IF WE ARE UNABLE TO CONTACT YOU OR ANY OF THE ABOVE INDIVIDUALS AND YOUR CHILD IS SICK OR INJURED, BY VIRTUE OF YOUR SIGNATURE BELOW, YOU AFFORD US **PERMISSION** TO IMMEDIATELY SEEK, THE NECESSARY EMERGENCY MEDICAL ATTENTION FOR YOUR CHILD.

PARENT / GUARDIAN SIGNATURE: _____

PARENT / GUARDIAN PRINT: _____
ADVISORS SIGNATURE: _____

DATE RECEIVED: _____

WOLCOTT AMBULANCE EXPLORER POST #2166 PHOTO RELEASE

For explorers under18 years of age, complete the form below.

I, _____, Parent/Guardian of _____hereby authorize and consent to the use of his/her visual image by the Wolcott Ambulance Association Explorer Post 2166 for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications and websites. I give this consent with no claim for payment.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Member Name:_____

Member Signature: _____Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Phone_____ (in case we need to contact you).

For explorers 18 years of age or older, complete the form below.

I, _____, hereby authorize and consent to the use of my visual image by the Wolcott Ambulance Association Explorer Post 2166 for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications, and websites. I give this consent with no claim for payment.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Member Name: _____

Member Signature: _____ Date_____

Phone_____ (in case we need to contact you).