Granby Ambulance Association
PO Box 617
Granby, CT 06035
(860) 653-6535
www.granbyambulance.org

Application for Membership

Last Name: _____ Maiden Name: _____ First: _____ Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

E-Mail Address:_____ Cell/Mobile Phone_____

Have you previously applied for membership in GAA? NO YES **If yes,** date of previous application:_____

Employer Name: _____ Occupation:_____

Employer Address:_____

Supervisor: _____ Phone: _____ Date of employment: _____

PREVIOUS Employer Name: _____ Occupation:_____

PREVIOUS Employer Address: _____

PREVIOUS Supervisor: _____ Phone:_____ Date of employment: _____

May we contact your current employer? No Yes May we contact your previous employer? No Yes

Driver's License Number and State of issue:_____ Social Security Number: _____-_____-_____

Have you had any **traffic violations** or accidents within the past three (3) years? NO YES If **YES,** describe on back of this page.

Please circle any medical/first aid certifications you have:

CPR **MRT** **EMT** **LPN** **RN** **Paramedic**

Please list any other medical training, education or experience you feel is pertinent to service with Granby Ambulance Association:

_____

_____

_____

** *Please attach photocopies of all certifications cited above.*

Briefly describe your interest in seeking membership in the Granby Ambulance Association: _____

_____

_____

Please list three references whom you have known at least six months and to whom you are not related. Include complete contact information.

Name Address Telephone Pager/Mobile Phone

_____

_____

_____

Your signature at the end of this document gives express permission to the Granby Ambulance Association, Inc to contact the persons identified above as references.

Have you ever been convicted of a crime other than a traffic violation? ? No Yes If Yes, explain.(attach additional documentation as necessary).

_____

_____

Do you agree to permit the Granby Ambulance Association to check your driving history with the department of motor vehicles ? No Yes

Do you agree to furnish proof of medical certification for the position of Emergency Medical Technician (EMT) or Medical Response Technician (MRT) ? No Yes

Please indicate your availability: Weekday No Yes Nights No Yes Weekends No Yes

Personal Background Check

I authorize the Granby Ambulance Association, Inc. to contact the Granby Police Department, the Connecticut State, any similar police agency of a state where I have resided in the past three years, as well as any investigative firm, for the purpose of identifying any criminal convictions or civil actions which will disqualify me from membership with Granby Ambulance Association.

Signature: _____ Date: _____

Motor Vehicle Authorization

I authorize the Granby Ambulance Association, Inc. to contact the Granby Police Department and/or the Department of Motor Vehicles of the State of Connecticut, or any similar motor vehicle agency of a state where I have had a driver's license or privileges in the past three years, for the purpose of identifying any restrictions, violations or accidents which might restrict or otherwise interfere with my ability to operate an ambulance.

Signature: _____ Date: _____

Other Information:

_____

_____

_____

Applicant's Certification

I certify that the information given in this application is true and correct to the best of my knowledge. I further understand that any intentional falsification, omissions or failure to execute any required authorizations contained herein shall result in non-consideration for membership and/or termination of membership in the future. I agree to follow the rules of Granby Ambulance Association as set forth in the Bylaws and Policies and Procedures. I agree to update any information in this application that changes by written notification to Granby Ambulance Association Chief of Service.

Signature: _____ Date: _____