



MADISON VOLUNTEER AMBULANCE CORPS

P.O. Box 626
Business Tel. No.: 973-377-2229

29 Prospect Street, Madison, NJ 07940
Fax No.: 973-377-0312

Dear Applicant,

Thank you for your interest in the MADISON VOLUNTEER AMBULANCE CORPS (MVAC), which provides emergency medical services free of charge to the community of Madison and neighboring towns, 24 hours a day, 7 days a week.

The minimum requirements to join MVAC are as follows: 1) you must be at least 17 years of age; 2) you must live, work, or go to school in Madison and be willing to remain in Madison during your shift, and you must hold a valid driver's license.

Enclosed are the following items to be completed entirely and returned in the self-addressed envelopes: 1) Application 2) Physical Exam 3) Hepatitis B Form 4) Personal Reference 5) Professional Reference. If you have had a physical within one year, the doctor may sign the form without conducting another exam, however any physical over one year is not valid. The two references need to be completed by an adult other than relatives. Members who are under the age of 18 must have parental permission to stay on duty past midnight. Upon receipt of your completed application, we will contact you to set up an interview. We conduct driver's license and criminal background checks on all applicants. Please feel free to direct any questions to us at the number listed below.

Following your interview, you will be notified of the Executive committee's decision regarding your eligibility for membership. Once accepted, you will be asked to attend the next scheduled meeting, which is generally the second Wednesday of the month. At this meeting you will be sworn in and take the membership oath.

Members are asked to ride at least one 12-hour shift per week and we will work with you to coordinate a shift that both fits your needs and that of the Corps. Our shifts run from 7am to 7pm and 7pm to 7am. You will join a crew of 3 to 4 people comprising your Crew Chief, Driver and possibly other members. Your Crew Chief will advise you as to how they handle their particular shifts. Generally, most crews meet at the building a few minutes prior to the start of their tour to go through a checklist to insure all the equipment is operational. Members are asked to stay in town during their shift, however, you do not have to remain at the building.

All members must earn their Cardiopulmonary Resuscitation (CPR) certification within six months of induction and their Emergency Medical Technician (EMT) certification within one year of induction. CPR training usually takes 4 hours and EMT training is about 200 hours. MVAC or the State of NJ EMT training fund absorbs all costs for these courses.

Again, thank you for your interest in joining the MADISON VOLUNTEER AMBULANCE CORPS, and we look forward to having you as part of our team!

IN CASE OF AN EMERGENCY, **DIAL 9-1-1**



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APPLICATION FOR MEMBERSHIP

Name _____ Date of Application ____/____/____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ E-mail _____

Age ____ Date of Birth ____/____/____ S.S. Number _____

Driver License # _____/_____/_____ State _____

Have you ever been a member of another First Aid, Rescue Squad or Fire Department?

_____ If yes, list the name(s) of the organization, phone #, dates of service and name of contact person.

Have you ever been denied membership in a volunteer organization? If yes, please explain.

Have you ever been a member of the Madison Volunteer Ambulance Corps? _____

If yes, please list dates: From: ____/____/____ To: ____/____/____

Are you acquainted with anyone on the Madison Volunteer Ambulance Corps? If yes, please list their name(s)

EDUCATION

Circle Highest Year Completed School Attended Major

High School 9 10 11 12 _____ Vocational 1 2 3 4 _____

College 1 2 3 4 _____ List all certificates, degrees, diplomas, etc.

EMPLOYMENT INFORMATION (If you have several part-time jobs, list information

on back and check here _____)

Company Name: _____

Address: _____

Number of years employed: _____ Occupation: _____

Supervisor's Name: _____ Title: _____ Phone: _____

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OTHER

Has your drivers' license ever been suspended or revoked? _____ If yes, please explain:

Have you had any moving violations within the past 3 years? (Including accidents or summonses) _____ If yes, please list: _____

Have you ever been convicted of a criminal offense? _____ If yes, please explain:

AVAILABILITY

Please list the times that you feel you would be able to be on ambulance duty.

Day	Times
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____
Sunday	_____

What motivated you to apply for membership to the Madison Volunteer Ambulance Corps?

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ATTENTION ALL APPLICANTS

I understand that I may be exposed to emergency situations which can lead to post traumatic stress as well as exposure to serious illness, which are normal occupational hazards, and as such, liability for such exposure is limited to that provided under applicable New Jersey Workers Compensation law and benefits by Workers Compensation insurance. I understand that the Madison Volunteer Ambulance Corps reserves the right to conduct driver's license and criminal background checks on all applicants.

ATTENTION ALL HEALTH CARE PROVIDER APPLICANTS (M.D., R.N., L.P.N., OR PARAMEDICS)

Persons providing Basic Life Support (EMT-A or EMT-B) level care as members of the Madison Volunteer Ambulance Corps are covered by insurance provided by the Corps; however health care professionals who may provide care beyond the scope of Basic Life Support (EMT-A or EMT-B) are not covered by the Corps malpractice insurance and should have their own personal malpractice insurance. I hereby apply for membership in the Madison Volunteer Ambulance Corps. If accepted, I agree to abide by the rules and regulations of the Corps, and will take the following oath of membership:

I solemnly swear that I shall live up to the ideals and traditions of the Madison Volunteer Ambulance Corps. I agree to fulfill my duty obligations; to regularly attend meetings and drills; to assist in the orderly maintenance of the Corps; to refrain discussing with non-members details connected with the work of the Corps; to neither expect or accept financial compensation for anything done toward carrying out our purpose as outlined; and upon retiring from membership to return to the Corps any property belonging thereto.

By signing below, I agree to begin my EMT training within one year of becoming a member of the Madison Volunteer Ambulance Corps and my CPR training within 6 months. I further agree that if the minimum level of training, as required by the New Jersey State First Aid Council, is not met and kept current that this statement may be considered my resignation from the Corps.

By signing below, I agree that I am responsible to ride a minimum of one full 12-hour shift per week. I also understand that all crews are rotated through the Saturday day shift, and agree to fill that shift with my regular crew's rotation, about once every three months; and will attend the mandatory eight out of eleven monthly meetings, held every second Wednesday of every month excluding August. I certify that, to the best of my knowledge, the information in this application is true and accurate. The Madison Volunteer Ambulance Corps reserves the rights to verify any and all information on this application with the appropriate authorities.

Signature _____ Date ____/____/____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____ Address _____

Phone # _____ Relationship _____

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ATTENTION APPLICANTS UNDER THE AGE OF 18

Applicants under the age of 18 are required to have written consent from their parent or legal guardian before becoming a member of the Madison Volunteer Ambulance Corps. I hereby give my son/daughter _____ permission to become a member of the Madison Volunteer Ambulance Corps. I understand that my child may be exposed to emergency situations which can lead to post traumatic stress as well as exposure to serious illness, which are normal occupational hazards, and as such, liability for such exposure is limited to that provided under applicable New Jersey Workers Compensation law and benefits by Workers Compensation insurance.

Signature _____ Date ____/____/____

I hereby give my son/daughter _____ permission to ride past midnight.

Signature _____ Date ____/____/____

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REFERENCE QUESTIONNAIRE PROFESSIONAL

Re: _____

(Applicant's name)

The above applicant has applied for membership with the Madison Volunteer Ambulance Corps and has offered your name as a reference.

To assist us in determining this candidate's eligibility for membership, we would appreciate your completing this questionnaire and returning it at your earliest convenience. Please be assured that your response will be held in strict confidence. Should you have any questions or concerns please feel free to call the Membership Chair at 973-224-7459.

Thank you for your assistance.

1. How long, and in what capacity, have you known the candidate?

2. How would you rate this candidate's dependability?

3. How would you evaluate this candidate's initiative?

4. Please comment on the integrity of this candidate.

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5. In your opinion, is this candidate able to perform under stressful situations? If possible, please provide an example.

6. To your knowledge, has this candidate been involved in activities that demonstrate concern for others? Please describe.

7. Can you offer any further insights regarding this candidate's qualifications to become a member of the Madison Volunteer Ambulance Corps?

Signature _____ Date ____/____/____

Please print name, address and phone number:

REFERENCE QUESTIONNAIRE

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PERSONNAL

Re: _____

(Applicant's name)

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6. To your knowledge, has this candidate been involved in activities that demonstrate concern for others? Please describe.

7. Can you offer any further insights regarding this candidate's qualifications to become a member of the Madison Volunteer Ambulance Corps?

Signature _____ Date ____/____/____

Please print name, address and phone number:

HEPATITIS B VACCINATION RECORD

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The Madison Volunteer Ambulance Corps strongly recommends that you receive this vaccination. You may use your family doctor, or receive the shots at Morristown Memorial Hospital's Work-Med Office (973-971-5904). The Corps will reimburse you upon submission of proof of payment. If you have already received the vaccine, fill in the dates of your vaccinations below. If you choose not to receive the vaccine at this time, read and sign the declaration below. Return this form to the Captain or First Lieutenant as soon as possible.

Name _____

Hepatitis B Vaccination Record

Vaccination	Date	Signature
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____

Hepatitis B Vaccine Declination

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 the hepatitis B vaccine, at no charge to myself. However, I decline hepatitis 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.

Signature _____

Date _____

Witness _____

Witness _____

CONFIDENTIAL PHYSICAL EXAMINATION

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Name: _____

Past History (general health, illness – including heart, back problems, surgery, etc.)

Resistance to fatigue/stress _____ Blood Pressure ____/____

Hearing _____

Heart and vascular system _____

Lungs _____

Neck _____

Extremities _____

Abdomen (scars, hernia, condition of wall) _____

Spine (including posture) _____

Urinalysis _____

Is there any present indication of substance abuse? _____

Is there any indication of nervousness disorder or mental condition that would make the applicant unable to work under pressure? _____

Is the applicant in good physical condition for volunteer service as a member of the Madison Volunteer Ambulance Corps, including his/her ability to lift patients? _____

Name _____

(Examining physician – please print or stamp)

Signature _____ Date _____

Address _____

Upon completion, this form should be mailed or delivered to:

Madison Volunteer Ambulance Corps Attn: Membership Chair
29 Prospect Street
Madison, New Jersey 07940

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