Lima Volunteer Ambulance

7024 W. Main St.
P.O. Box 335
Lima, NY 14485
+1 5856242221

Application For Membership

Name: _______________________________________ Date of Birth: ___________________

Address: ____

City: ________________________________ State: ______________ Zip Code: ____________

Email: ____

Phone Number: _________________ Driver License Number: _________________

Position Applied For: ☐ Driver ☐ EMT ☐ Assistant ☐ Other

Certifications: ☐CPR ☐CFR ☐EMT-B ☐EMT- A ☐Paramedic ☐ EVOC/CVO
Other: ____ CFR/EMT #: _______________

Have you been a past member with Lima Volunteer Ambulance ☐ Yes ☐ No
If yes what year were you an active member: _______________

Have you have ever been or currently in EMS or Firefighter or Law Enforcement: ☐ Yes ☐No If yes, please list the agency
Agency: _____________________________ Active: ☐ Yes ☐ No
Agency: _____________________________ Active: ☐ Yes ☐ No
Agency: _____________________________ Active: ☐ Yes ☐ No

Have you ever been convicted of, or enter a plea of guilty, no contest, or had a withheld judgment to a felony ☐ Yes ☐ No If Yes please explain: ____
____
____

Have you ever had any traffic violations including accidents in the past 5 years ☐ Yes ☐ No if yes please explain:____
____
____

Availability (Please note the time you prefer to volunteer)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

☐ Anytime works for me ☐ Unable to predict at this time

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Personal References:

Name ____ Phone Number __________________
Address ____

Name ____ Phone Number __________________
Address ____

A. ACCURACY: By signing below you attest that information you have provided on this application is accurate and complete and provided without deception, coercion, or omission to the best of your knowledge. Further, you assess that based on your knowledge of the applicant's health that the applicant is capable of meeting the physical and emotional requirements to serve as a member of Lima Ambulance.

B. MEDICAL RELEASE: In the event of illness or injury occurring to the applicant while involved in Lima Volunteer Ambulance activities, I consent to x-ray examination, anesthesia, and / or medical or surgical diagnostic procedures or treatment considered necessary in the best judgment of the senior medical professional in charge and performed by or under the supervision of a member of the medical staff of the medical facility furnishing medical services. I understand that in the event of serious illness or injury, reasonable efforts to reach an emergency contact will be made.

C. BACKGROUND CHECK: I authorize all licensing agencies, educational institutions, law enforcement agencies, present and former organizations, and the military services to disclose their relevant records about me to the Village of Lima Ambulance whether the information be of a public, private, or confidential nature; and I release Village of Lima Ambulance and all affiliates and I hold them harmless from any liability resulting there from. This authorization, in original copy form, shall be valid for this and any future information, reports or updates that may be requested. I acknowledge and understand that the Village of Lima Ambulance, through New York State, will be conducting a background check on me. I authorize the Village of Lima Ambulance and New York State to do so.

Applicant Signature: ____

Date: ____