P.O. Box 743, Englewood, New Jersey 07631

www.englewoodvac.com **201-569-7962**

Thank you for your interest in joining the Englewood Volunteer Ambulance Corps. Below are some of the requirements for membership:

- ✓ Ride a minimum of one six-hour shift each week.
- ✓ Pass a Criminal Background Check.
- ✓ Pass a pre-Membership physical exam.
- ✓ Become a Certified NJ State Emergency Medical Technician or an Emergency Responder within 12 months of joining. Course cost varies from $750 to $1500 for EMT training and books are an additional $200. Course length is approximately 250 hours. In many cases training expenses will be reimbursed upon successful completion of the EMT class and an agreed upon length of service to the Ambulance Corps, as per a signed contract with EVAC.

The benefits of membership are highly rewarding

- ➢ Personal satisfaction in helping the citizens of Englewood and surrounding towns in their time of need.
- ➢ Professional emergency medical training.
- ➢ Expanded life experience.

As an unpaid volunteer member of the Englewood Volunteer Ambulance Corps, you will serve in one of the three major public service agencies in the City of Englewood. Your sincere participation and dedication ensures that quick and effective medical assistance gets to those who need it. Membership in the Englewood Volunteer Ambulance Corps represents an important responsibility and commitment to other people in the community.

Instructions to complete this application:

♦ Please print legibly.
♦ Please complete all sections of the application.
♦ List two references on the application and have the two Letter of Reference forms completed by the same people listed on the application.

*References **cannot** be relatives and you should know them for more than a year!*

♦ Your application cannot be processed until BOTH Personal Letter of Reference forms are returned.
♦ If you intend to drive one of EVAC's vehicles, you must obtain your driver's license abstract and return it to EVAC.

Thank you for your interest.

The members of the Englewood Volunteer Ambulance Corps

Revised 09/2015

P.O. Box 743, Englewood, New Jersey 07631	EVAC USE ONLY Interview Date ____________________ Interviewed By ____________________ Medical Report: ___________________ Police Report: ____________________ Elected To Probation _______________ Elected to Full Membership __________

Date ___/___/_____

Name ____

Address ____

City_________________________________ State _____________ Zip _____________

How long at current address? ____

Previous Address____

City _________________________________ State _____________ Zip _____________

Preferred telephone #____________________________(Home/Mobile)

Alternate telephone #____________________________(Home/Mobile)

E-Mail Address ____

Date of Birth ___/___/____ Social Security # ______________________________

Driver's License # _________________________ State_________ Expiration ___/___/____

Current Employer _________________________ Supervisor ______________________

Work telephone # ______________________ How long have you worked there? _____________

Why do you want to join the Englewood Volunteer Ambulance Corps, Inc.?

____

____

____

Related Experience and Training:

Have you ever been a member of EVAC? YES / NO If so when? _____________

Have you ever been a member of any Commercial or Volunteer Ambulance Corps or Fire Department? YES / NO

If yes, what agency and when? ____

Are you still a member? YES / NO If no, why did you leave?

____

Are you currently a member of any other Emergency Services (Fire, Rescue, Police, Paramedic)?

YES / NO If yes, what agency? ____

EMS Training

CPR YES / NO Expiration ___/___/____ 1st Responder YES / NO Expiration ___/___/____

EMT YES / NO Expiration ___/___/____ Haz-Mat YES / NO Expiration ___/___/____

ICS-100 YES / NO Date ___/___/____ ICS-200 YES / NO Date ___/___/____

ICS-700 YES / NO Date ___/___/____ Other YES / NO Date ___/___/____

Please list and explain any other medical or non-medical training or experiences you feel may be an asset to EVAC. ____

____

Medical History

Do you have any physical limitations or medical issues (such as cardiac condition, hearing impairment, back problems, etc.) that could prevent you from performing the duties required by EVAC? YES / NO

Do you have any allergies? YES / NO If yes to either of the above questions, please list:

____

____

Personal References

EVAC requires two personal references. Each reference must complete and return one of the attached Personal Letter of Reference Forms and return it to EVAC. Personal references cannot be relatives.
Please list the two people you will give the forms to:

Name: ____
Address: ____
____
Phone number:__________________________________

Name: ____
Address: ____
____
Phone number:__________________________________

ALL REFERENCE FORMS MUST BE RETURNED PRIOR TO ACCEPTANCE!

Criminal and Driving History

Have you ever been convicted of any crime in New Jersey or elsewhere? YES / NO

If yes, please explain: ____

____

____

If you intend to eventually drive any one of EVAC's emergency vehicles, you must provide the following information:

Do you have any active points against your license? YES / NO

Has your license ever been suspended? YES / NO

If yes to either, please explain: ____

____

Please list any moving violations that you have had in the past 18 months:

____

____

Please list any accidents that you have had in the past 3 years:

____

____

I hereby authorize inquiry by EVAC of all statements contained in this application and release those individuals from any and all liability and damage resulting from or arising out of such investigations. I understand that any misrepresentation or omission of facts in this application is cause for immediate dismissal from the Corps.

I consent to taking a pre-Membership physical exam and such future exams as may be required by the Corps. I agree to comply with EVAC's Constitution and By-Laws and all Policies and Procedures governing EVAC, and further agree to return any and all equipment and/or clothing loaned to me by the Corps upon relinquishing my membership in EVAC.

I HEREBY DECLARE THAT ALL OF THE ABOVE STATEMENTS ARE TRUE.

Applicant's signature ___________________________________ Date ___/___/____

Parent's signature (if applicant is under 18) __________________ Date ___/___/____

Date of Birth ____________________________

INFORMED CONSENT FOR HEPATITIS B VACCINE

The Disease:

Hepatitis B is a viral infection caused by hepatitis B virus (HBV), which mainly affects the liver. The virus most often is spread through blood and blood products but may also spread through tears, saliva, urine, breast milk, semen and vaginal secretions. The serious complications of this disease include necrosis of the liver, cirrhosis of the liver, chronic active hepatitis and cancer of the liver. There is no specific treatment for this disease. Most people with hepatitis B recover completely but one to two percent (1-2%) result in death and five to ten percent (5-10%) become chronic carriers of the virus. Chronic carriers often have no symptoms but can continue to transmit the disease to others.

Immunization against Hepatitis B can prevent acute hepatitis and can also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

The Vaccine:

Engerix-B [Hepatitis B Vaccine (Recombinant)] is a noninfectious recombinant DNA hepatitis B vaccine developed and manufactured by SmithKline Biologicals and distributed by SmithKline & French. It contains purified surface antigen of the virus obtained by culturing genetically engineered Saccharomyces cerevisiae cells, which carry the surface antigen gene of the hepatitis B virus. The surface antigen expressed in Saccharomyces cerevisiae cells is purified by several physiocochemical steps and formulated as a suspension of the antigen absorbed on aluminum hydroxide. The procedures used to manufacture "Engerix-B" result in a product that contains no more than 5% yeast protein. Each 1 mL adult dose of vaccine consists of 20 mcg. of Hepatitis B surface antigen absorbed on 0.5 mg. aluminum as aluminum hydroxide. The vaccine contains 1:20,000 Thimerosal (mercury derivative) as a preservative. The duration of immunity is unknown at this time.

Dosing Schedules:

The usual immunization regimen consists of 3 doses of vaccine given according to the following schedule:

1st dose: at elected date
2nd dose: 1 month later
3rd dose: 6 months after first dose

Contraindications:

Hypersensitivity to yeast or any other component of the vaccine (aluminum, hydroxide, Thimerosal-mercury derivative, sodium chloride and Phosperate buffers) is a contraindication for use of the vaccine.

Precautions:

1. Any serious active infection is reason for delaying vaccination.
2. Pregnancy - it is not known whether the vaccine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity.
3. Nursing mothers - it is not known whether the vaccine is excreted in human milk.

Warnings:

Patients experiencing hypersensitivity after an "Engerix-B" [Hepatitis B Vaccine (Recombinant)] injection should not receive further injections of "Engerix-B" (See Contraindications).

Hepatitis B has a long incubation period. Hepatitis B vaccination may not prevent hepatitis B infection in individuals who have an unrecognized hepatitis B infection at the time of vaccine administration. Additionally, a small percentage of healthy people do not respond to the vaccine and do not develop immunity to the HBV.

Possible Side Effects:

Most Common: Local reaction at injection site; pain, tenderness & warmth, erythema & swelling.

Less Common: Fever, fatigue, headache, dizziness, flushing, tingling, hypotension, influenza, influenza-like symptoms; upper respiratory tract illnesses, nausea, anexoria, abdominal pain/cramps; vomiting; constipation; diarrhea; Lymphadenopathy; pain/stiffness in arm, shoulder or neck & back; pain & arthritis.

Potential Adverse Effects:

Nervous System: Insomnia, irritability, agitation, migraine, syncope, Guillain-Barre syndrome & Bell's palsy, transverse myelitis & optic neuritis.

Hematologic: Thrombocytopenia.

Cardiovascular System: Tachycardia / palpitations.

Respiratory System: Bronchospasm including asthma-like symptoms.

Skin and Appendages: Eczema; purpura; Herpes Zoster.

Special Senses: Vertigo; conjunctivitis; visual disturbances.

If you have any questions about Hepatitis B or the Hepatitis B Vaccine, please contact Dr. Harvey Gross.

ENGLEWOOD VOLUNTEER AMBULANCE CORPS

HEPATITIS B VACCINATION - CONSENT FORM

"To my knowledge I am not allergic to yeast or any other component of the vaccine." "I do not have an active infection."

For Women:

"I am not a nursing mother."

"I understand that I should not receive this vaccine if I have any reason to believe that I might be pregnant now and I acknowledge that I do not believe that I am or might be now pregnant.

"I have read the statements about hepatitis B and the hepatitis B vaccine, have had an opportunity to ask questions, discuss the vaccine, its potential side effects and complications. I understand the risks and benefits of the vaccine and further understand that I must have three (3) doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me or to the person named below of whom I am the parent or guardian."

"By signing this form and hereby consenting to Hepatitis B immunization, I certify that I have no religious, medical or other objection to having the hepatitis vaccine administered to me. I also release the Englewood Volunteer Ambulance Corps, Inc. from any liability arising therefrom."

____ _______________
Name of Person To Receive Vaccine (Print or Type) — Date

____ _______________
Signature of Person Receiving Vaccine or Parent or Guardian — Date

Office Use Only:

	Date Vaccinated	**Lot Number**
1.		
2.		
3.		

Revised 1/11/04

ENGLEWOOD VOLUNTEER AMBULANCE CORPS

HEPATITIS B VACCINATION - DECLINATION FORM

NAME: ____

Complete either Section A or Section B:

Section A:
I understand that due to my occupational exposure (as a member of the Englewood Volunteer Ambulance Corps, Inc.) 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 hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B 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.

____________________________________	______________________
Member's Signature	Date
____________________________________	______________________
Signature of Parent or Guardian	Date
____________________________________	______________________
Signature of EVAC Representative	Date

Section B:
I understand that due to my occupational exposure (as a member of the Englewood Volunteer Ambulance Corps, Inc.) 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 Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. The reason for my declination is that I have already received the Hepatitis B vaccine prior to my becoming a member of the Englewood Volunteer Ambulance Corps, Inc. I am indicating below the dates and lot numbers of my previous Hepatitis B vaccination series.

____________________________________	______________________
Member's Signature	Date
____________________________________	______________________
Signature of Parent or Guardian	Date

	Date Vaccinated	**Lot Number**
1.	____________________	____________________
2.	____________________	____________________
3.	____________________	____________________

Physician administering vaccine: ________________________________ ______________________

Signature Date

Revised 1/11/04

P.O. Box 743, Englewood, New Jersey 07631

www.englewoodvac.com **201-569-7962**

Personal Letter of Reference

Dear Sir or Madam:

The person you are providing this reference for is in the process of applying for membership in the Englewood Volunteer Ambulance Corps, Inc. The applicant has chosen you as a person qualified to render a fair opinion of their suitability for membership.

Please complete and sign this form as soon as possible. The applicant will not be considered for membership until we receive your letter of reference. Please mail this form to the address noted on the bottom. This information will be held in the strictest confidence.

This letter of reference is for (name of applicant): ______________________________________

In what capacity do you know this person?

☐ Personal Friend ☐ Acquaintance ☐ Colleague at work

☐ I am not really qualified to comment on this person

How long have you known this person? _________years

Do you understand that the person named above is applying for membership to EVAC and the nature of the business that EVAC is in? YES / NO

Do you recommend this person for membership into EVAC?

☐ Highly Recommend ☐ Recommend ☐ Do NOT Recommend ☐ No Comment

Please explain why you recommend or do not recommend this person for EVAC membership:

____

____

____

****Additional comments may be made on the back of this sheet****

Your Name: ____

Address: ____

____

Phone Number: _____________________________

The best time to call if further information is needed:______________________________________

(Signature)_________________________________ (Date)____________________________

Please mail completed form to: Englewood Volunteer Ambulance Corps, Inc.
P. O. Box 743, Englewood, New Jersey 07631-0743

If you have any questions, please contact us at 201-569-7962. Thank you.

Revised 09/2015

P.O. Box 743, Englewood, New Jersey 07631

www.englewoodvac.com 201-569-7962

Personal Letter of Reference

Dear Sir or Madam:

The person you are providing this reference for is in the process of applying for membership in the Englewood Volunteer Ambulance Corps, Inc. The applicant has chosen you as a person qualified to render a fair opinion of their suitability for membership.

Please complete and sign this form as soon as possible. The applicant will not be considered for membership until we receive your letter of reference. Please mail this form to the address noted on the bottom. This information will be held in the strictest confidence.

This letter of reference is for (name of applicant): ____

In what capacity do you know this person?

☐ Personal Friend ☐ Acquaintance ☐ Colleague at work

☐ I am not really qualified to comment on this person

How long have you known this person? _________years

Do you understand that the person named above is applying for membership to EVAC and the nature of the business that EVAC is in? YES / NO

Do you recommend this person for membership into EVAC?

☐ Highly Recommend ☐ Recommend ☐ Do NOT Recommend ☐ No Comment

Please explain why you recommend or do not recommend this person for EVAC membership:

____

____

____

****Additional comments may be made on the back of this sheet****

Your Name: ____

Address: ____

____

Phone Number: ______________________________

The best time to call if further information is needed:____

(Signature)__________________________________ (Date)______________________________

Please mail completed form to: Englewood Volunteer Ambulance Corps, Inc.
P. O. Box 743, Englewood, New Jersey 07631-0743

If you have any questions, please contact us at 201-569-7962. Thank you.

Revised 09/2015

P.O. Box 743, Englewood, New Jersey 07631

Physical Examination Authorization for Membership Application

Name: ____

I have examined the above named person and find him/her to be in good health and physically fit to participate in all activities of the Englewood Volunteer Ambulance Corps, Inc.

Physician signature: ____

Date: ___________________________

Physical examinations will be performed by the Corps Physician at his office at no cost to the prospective member. If you wish to use your own physician, you do so at your own expense.

Corps Physician:
Dr. Harvey Gross
370 Grand Ave.
Englewood, NJ 07631
201-567-3370

IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJPRR0000	VCP	13:59-1	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
VOLUNTEER CARE PROVIDER		VS1	$28.70
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
VCP			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number ( ) -	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	
(20) Home Address Address	City	State	Zip	
(21) Gender (Select one) [ ] Female [ ] Male [ ] Both	(22) Hair Color	(23) Eye Color	(24) Race (Select One) [A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown	
(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) Employer Address: ENGLEWOOD VOLUNTEER AMBULANCE CORPS, INC. P.O. BOX 743 City: ENGLEWOOD State: NJ Zip: 07631-0743			

Identification Requirement - *Acceptable Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria: Photo, Name, Address (home/employer), Date of Birth. Acceptable ID must be issued by a Federal, State, County or Municipal entity for identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ This Form Carefully:

Follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY.*** *It is* ***required*** *that you* ***present*** *this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.*

Appointment Scheduling:

Scheduling is available anytime at **www.bioapplicant.com/nj.** Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an applicant is responsible for payment, payment is required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, prepaid debit cards, or electronic debit (ACH) from a checking account. Accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 plus tax ($10.70) will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment, inability to present proper identification, inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2, or the information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 plus tax ($10.70) appointment fee. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information:		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM