

APPLICATION

**MACEDON
TOWN
AMBULANCE,
INC.**

Instructions

- Fill out applications on pages 3 and 4 as completely as possible.
- You will find consent forms for Hepatitis B vaccine and the Tuberculosis screening program on pages 7 and 8. The applicant must sign and return these forms with the application.
- A Medical Release form is attached to this booklet on pages 9 and 10. Please detach the Medical Release form from the application booklet and give it to your physician to fill out and return to the MTA, following the instructions listed on the form.
- As part of the application process you will be contacted by a member of the MTA's membership committee to set up an appointment for an interview.

The completed application will then be reviewed and voted upon by the MTA's Board of Directors at their monthly meeting.

Please be sure to return the medical release and copies of all certification cards and/or driver's license (if applying as driver) with your completed application. You can return your application in person or mail to:

**Macedon Town Ambulance, Inc. (MTA)
32 Main Street
Macedon, New York 14502**

***Application for Membership
Macedon Town Ambulance, Inc.***

PERSONAL INFORMATION

(All information submitted on this form will be kept confidential)

Name _____	Occupation _____
Street _____	Employer _____
City _____	Date of Birth _____
State/Zip _____	Phone No. _____
NYS Driver's License _____	Who to contact in case of an emergency _____
Social Security No. _____	_____

TRAINING INFORMATION

TRAINING

CHAPTER

EXPIRATION

Community CPR	_____	_____
Adult CPR	_____	_____
Infant & Child CPR	_____	_____
Basic First Aid	_____	_____
First Aid in the Workplace	_____	_____
CPR for the professional rescuer	_____	_____
Instructor: _____		
Basic Life Support CPR	_____	_____

OTHER

NYS EMS CERTIFICATION

NYS EMT No. _____

Level of Certification

Expiration Date

CFR (Certified First Responder)	_____
EMT-B	_____
EMT-1 (Intermediate)	_____
EMT-CC (Critical Care)	_____
EMT-P (Paramedic)	_____

**PERSONAL INFORMATION
(CONTINUED)**

Please list any other training you have received related to first aid or health care (i.e. Nursing, Armed Services, employee training, etc. _____

Are you currently enrolled in: First Aid or EMT training? If yes, where _____
_____ Completion Date: _____/_____/_____

Please list any experience with an ambulance, rescue squad, fire department, or health facility.

What made you decide to apply for membership with MTA? _____

What skills or interest do you have that may relate to MTA? _____

Do you know any members of MTA? _____

Please list three (3) personal or employer references (excluding MTA members).

Name _____	Phone _____	Address _____
Name _____	Phone _____	Address _____
Name _____	Phone _____	Address _____

Please list any chronic medical problems that may affect your abilities with MTA: _____

How do rate you general health? Poor Fair Good Excellent

Have you ever been convicted of a felony charge in any state, District, Commonwealth or Territory of the United States or Canada? Or, as of this application date, do you have any charges pending against you which are or would constitute a felony. YES NO

If you checked yes, explain: _____

I certify that I have examined this completed application and to the best of my knowledge it is true, correct, and complete. It is understood that the information contained in this application is for the sole use of MTA and will not be released without my written permission. Any false statements made in this application could result in immediate suspension or expulsion from membership in the Macedon Town Ambulance, Inc.

Signed _____ Date _____

MEMBERSHIP COMMITTEE APPLICATION REPORT

Application for membership report for: _____

Interview date scheduled ____/____/____ Interview conducted on: ____/____/____

Comments from interviewing committee members: _____

Signatures: 1. _____ Date: ____/____/____
2. _____ Date: ____/____/____
3. _____ Date: ____/____/____

Presented to the Board of Directors:

President _____

Action taken:
 Approved for membership Rejected for membership Refer back to committee

Comments of the membership committee:

Signed by Membership Chairperson: _____ Date: ____/____/____

Re-presented to the Board of Directors

President _____ Date: ____/____/____

Action taken: Approved for membership Rejected for membership

Notification of action

Director of Operations _____ Date ____/____/____
Letter sent to applicant _____ Date ____/____/____
Application placed on file _____ Date ____/____/____

WHAT IS HEPATITIS B

Hepatitis B is a serious disease caused by a virus that attacks the liver.

The Virus, which is called Hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Hepatitis B vaccine prevents both HBV infection and those diseases related to HBV infection.

The vaccine, which has been available since 1982, is given as a series of three intramuscular doses. Persons who respond to the Hepatitis B vaccine are protected against acute Hepatitis B as well as the chronic consequences of HBV infection, including cirrhosis and liver cancer.

The most common side effects from Hepatitis B vaccination are pain at the injection site and mild to moderate fever.

*Information supplied by the
Center for Disease Control, January 2001*

Consent/Refusal Form for Hepatitis B Immunization

Consent Form

I acknowledge that I have been informed of the risk of Hepatitis B infection. I received background information about the hepatitis B vaccine series and have been offered the opportunity to receive the Hepatitis B vaccine series at no cost through the below named organization.

Organization: _____

I wish to receive the Hepatitis B vaccine series.

I had the Hepatitis B vaccine series on the following dates:

_____/_____/_____/_____/_____/_____/_____/_____/_____/_____

Name: _____
print your full name - Last/First/Middle

Social Security No. _____

Signature: _____ Date: ____/____/____

Refusal Form

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the 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 vaccinations 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 the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

(taken from: FR Doc. 91-2886 Filed 12/2/91 @ 8:45 a.m.)

Name: _____
print your full name - Last/First/Middle

Social Security No. _____

Signature: _____ Date: ____/____/____

**Tuberculosis Screening Program
Non-participation Form**

I understand that due to my occupational exposure to tuberculosis (TB) I may be at risk of acquiring TB through airborne transmission of droplets, spread by an infected patient. I have been given the opportunity to be screened for the tuberculin bacteria, at no charge to myself. I understand that by declining this screening, I continue to have occupational exposure to TB, a serious disease. If in the future I continue to have occupational exposure to potentially infected patients and I want to be screened for TB, I can receive the TB test at no charge to me.

Name: _____
print your full name - Last/First/Middle

Signature: _____ **Date:** ____ / ____ / ____

**Tuberculosis Screening Program
Consent Form**

I acknowledge that I have been informed of the risk of Tuberculosis and that a screening provided by Macedon Town Ambulance, Inc. at no charge to me and consent to receive the test or acknowledge below that I have already received the test.

- I wish to receive the tuberculosis screening.**
- I had the tuberculosis screening on the following date:** ____ / ____ / ____

Name: _____
print your full name - Last/First/Middle

Signature: _____ **Date:** ____ / ____ / ____

Macedon Town Ambulance, Inc.

32 Main Street, Macedon, NY 14502
315.986.5932

Dear Doctor:

A patient of yours has applied for membership at Macedon Town Ambulance, Inc. The applicant must be in reasonably good health and must not have a medical problem that might be aggravated by the physical and emotional strains associated with emergency operations. Your patient must not need to take controlled drugs before or during duty. Please consider the duties of our emergency crew members and your patient's desired position.

■ **DISPATCHER:** Is in charge of the base facilities; responsible for the dispatching of up to three ambulances, receives, transmits and records radio messages for each emergency response, must answer three telephones, monitor several radio frequencies, and sometimes give First Aid to "walk-in" patients. There is often a great deal of emotional and mental stress involved in the performance of duties associated with the job of dispatcher.

■ **MEDIC:** Has primary responsibility for emergency and pre-hospital care of patients. In cases of multiple victims, or when caring for critical patients, there will be a great emotional strain on the Medic. The physical stress is great, as when lifting patients and gurney or doing CPR.

■ **MEDIC AIDE:** The duties are the same as Medic but does not have primary responsibility for patient care. A Medic Aide would be the third or fourth member of a crew.

■ **DRIVER:** Must assist the Medic in First Aid and obtain needed equipment. Physical stress is great as when lifting patients onto a gurney or doing CPR. Responsible for the safe transport of the emergency response crew and/or patient(s) and monitoring radio frequencies for communications. Road conditions and patient conditions can create a stressful situation.

All positions, except Dispatcher, are required to be capable of lifting a 125 pound patient on a gurney with the assistance of one other person.

Please complete the release form on the reverse side of this letter and thank you for your time and considerations on behalf of our applicant for membership.

Sincerely,

Director of Operations
Macedon Town Ambulance, Inc.

MTA Medical Release Form

This box to be completed by physician

I am aware of the physical and emotional stress involved in being a member of an ambulance crew.

In my opinion, _____ is capable of handling the duties of:

Dispatcher Medic Medic Aid Driver
(Check one or more boxes)

Physician's signature _____ Date ____ / ____ / ____

To be completed by member/applicant

Physician _____ Telephone No. _____

Address _____
Street Town Zip Code

I hereby authorize my physician to release to the officers of the Macedon Town Ambulance, Inc. any and all information as it applies to my ability to perform the duties as a dispatcher, medic, medic aide or driver for that organization. I also understand that this information will be deemed strictly confidential by said officers.

Applicant's Signature _____ Date ____ / ____ / ____

Your patient's consent authorizes permission only to the President or Director of Operations of Macedon Town Ambulance, Inc. to obtain additional information as required or needed should the situation arise and where deemed proper.

Upon request of the Board of Directors of the Macedon Town Ambulance, Inc., all new members are to have a physician's medical release.

Should there be any questions, you may refer them to the Macedon Town Ambulance, Inc. Director of Operations at 315.986.5932.