Summit Volunteer First Aid Squad
Application for Membership

Return to: Summit Volunteer First Aid Squad
Attn: Membership
P.O. Box 234
Summit, NJ 07902-0234

Visit us on the web: www.summitems.org

Personal Information				
First Name	Middle Name	Last Name	E-Mail Address	
Home Address - Street		City	State	Zip Code
Home Telephone ( )	Cell Phone ( )		Date of Birth	
Employer/School				
Employer/School Address		City	State	Zip Code
Employer/School Telephone ( )	Social Security #			
Driver's License Number	Issuing State	# Years Driving		

By signing this application I certify that all information contained herein is true. I further authorize the Summit Volunteer First Aid Squad to perform a criminal background check and a motor vehicle records check

Applicant Signature: Applicants under 18 years of age must have a legal guardian signature:

Indicate times available			First Aid Training	
	AM	PM	Card	Expiration Date
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Please provide the names of two persons who can provide personal references for you					
Name			Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Relationship			Relationship		
Number of Years Known			Number of Years Known		
Telephone ( )			Telephone ( )		

Is there any other training or experience which you feel would be applicable to the first aid squad?

_____

_____

Interviewed ____ Introduced ____ Proposed ____ Voted In ____ Personnel Lt. ____

Revised: April 2006