



Application for Membership/Employment

Applicant Name: _____

2330 Norton Street
Rochester, NY 14609
585-544-5112

Irondequoit Ambulance Application for Membership/Employment

Application Report

Office use only

Application received for: Membership Employment

Applicant: _____ Interviewed on: ____/____/____

Interview Comments:

Approved for membership / employment Rejected for membership / employment

Orientation / Internship:

Start date: ____/____/____ Completion date: ____/____/____

Probationary Period:

Start date: ____/____/____ Completion date: ____/____/____

End of probation status:

Active Resigned Terminated Probation extended

Name: _____ Signed: _____

Title: _____ Date: _____

Name: _____ Signed: _____

Title: _____ Date: _____

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Personal Information

(All information in this packet will be kept confidential and secured.)

Name: _____ Email: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____ Employer: _____

Phone: _____ Date of Birth: _____

Explorer Medic Driver Dispatcher Auxiliary Member

Emergency Contact Information

Please list at least one person to contact in case of an emergency

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Phone: _____

Phone: _____

Relationship: _____

Relationship: _____

Updated: __/__/__ Initial here: _____

Updated: __/__/__ Initial here: _____

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Training and Current Certifications

(All information in this packet will be kept confidential and secured.)

NYS Certification:

EMT#: _____ Expires: _____ N/A: _____

AEMT#: _____ Expires: _____ N/A: _____

CFR#: _____ Expires: _____ N/A: _____

CPR: yes no Expires: _____

Defensive Driving:

CEVO/EVOC Date acquired _____

Other:

Cert: _____ Expires: _____ Cert: _____ Expires: _____

Cert: _____ Expires: _____ Cert: _____ Expires: _____

Cert: _____ Expires: _____ Cert: _____ Expires: _____

Cert: _____ Expires: _____ Cert: _____ Expires: _____

- Are you currently enrolled in an EMT class: Yes No
If yes, when is your expected graduation date: _____
- Are you or have you ever been involved with any other Fire/EMS company? Yes No
If yes where? _____
- List any other qualifications you feel that would be helpful in the position that you are applying for:

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References and Background Information

Please list three personal references not related to you.

1. Name: _____ Address: _____ Phone: _____
2. Name: _____ Address: _____ Phone: _____
3. Name: _____ Address: _____ Phone: _____

I certify that I have examined this completed application and to the best of my knowledge it is true, correct and complete. Furthermore, I hereby authorize Irondequoit Ambulance to check any and all of the information and references for the purposes of membership/ employment with Irondequoit Ambulance.

It is understood that the information contained in this application is for the sole use of Irondequoit Ambulance and will not be released without my written permission. Any false statements made in this application could result in immediate suspension or termination from membership or employment from the Irondequoit Ambulance Corp.

Name: _____

Signed: _____

Dated: _____

Irondequoit Ambulance Application for Membership/Employment

As a member of Irondequoit Ambulance, we offer free Tuberculosis and Hepatitis B immunizations at no additional cost to you or your insurance provider.

What is Hepatitis B

Hepatitis B is a contagious liver disease that results from infection with the Hepatitis B virus. It can range in severity from a mild illness lasting a few weeks to a serious, lifelong illness. Hepatitis B is usually spread when blood, semen, or another body fluid from a person infected with the Hepatitis B virus enters the body of someone who is not infected. This can happen through sexual contact with an infected person or sharing needles, syringes, or other drug-injection equipment. Hepatitis B can also be passed from an infected mother to her baby at birth.

Hepatitis B can be either acute or chronic. Acute Hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the Hepatitis B virus. Acute infection can — but does not always — lead to chronic infection. Chronic Hepatitis B virus infection is a long-term illness that occurs when the Hepatitis B virus remains in a person's body. Chronic Hepatitis B is a serious disease that can result in long-term health problems, and even death.

The best way to prevent Hepatitis B is by getting vaccinated

Information obtained by the Center for Disease Control
<http://www.cdc.gov/hepatitis/B/index.htm>

Basic TB Facts

"TB" is short for tuberculosis. TB disease is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.

How TB Spreads:

TB is spread through the air from one person to another. The TB bacteria are put into the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.

Information obtained by the Center for Disease Control
<http://www.cdc.gov/tb/topic/basics/default.html>

Consent/Refusal Form for the Hepatitis B Immunization

Consent for Hepatitis B Immunization

I acknowledge 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 the Hepatitis B vaccine at no additional charge to myself.

I wish to receive the Hepatitis B Vaccine series.

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

1: ____/____/____ 2: ____/____/____ 3: ____/____/____

Name: _____

Signature: _____

Date: ____/____/____

Refusal for Hepatitis B Immunization

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.

I wish to receive the Hepatitis B Vaccine series.

Name: _____

Signature: _____

Date: ____/____/____

Consent/Refusal Form for the Tuberculosis Screening

Refusal for the Tuberculosis Screening

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: _____

Signature: _____

Date: ____/____/____

Consent for the Tuberculosis Screening

I acknowledge that I have been informed of the risk of Tuberculosis and that a screening at no charge to me is provided by Irondequoit Ambulance. I consent to receive the test or acknowledge below that I have already received this test within one calendar year of this application.

I wish to receive the tuberculosis screening.

I have had the tuberculosis screening on the following date: ____/____/____

Name: _____

Signature: _____

Date: ____/____/____

Consent for release for information

Irondequoit Ambulance Service Inc.
2330 Norton Street
Rochester, NY 14609
Phone: 585-544-5112 Fax: 585-544-1810

Release For Information

Name : _____
Last , First, Middle

Address: _____

Drivers License Number: _____ State of Issue: _____

Sex: _____ DOB: _____ SSN: _____

List all other Counties and States lived in during the past five years (other than the above address): _____

Statement of Authorization & Understanding I, _____, hereby authorize the release of any and all records and information concerning me, to include military records, motor vehicle records, criminal records, school records and personal data. I authorize any firm, person, or governmental agency to release any of the above information. I release, from liability, any person, firm or governmental agency who furnishes information in connection with this form. I also realize that any information provided by me, if found to be false, will be grounds for immediate dismissal from any employment or memberships with the Irondequoit Ambulance Service, Inc.

A copy and/or facsimile of this form shall be as valid as the original.

Signature of Applicant: _____ Date: _____

Signature of Witness: _____ Date: _____

Title of Witness: _____

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Member/Employee Confidentiality and Non-Disclosure Agreement

I _____ understand that Irondequoit Ambulance provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of Irondequoit Ambulance's patients. I understand that it is necessary, in the rendering of Irondequoit Ambulance services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such information is strictly confidential and protected from improper use and disclosure by federal and state laws.

I agree that I will comply with all confidentiality and security policies and procedures set in place by Irondequoit Ambulance during my tenure as a member/employee with Irondequoit Ambulance. If at any time I knowingly or inadvertently breach the patient confidentiality or security policies and procedures, I agree to notify the Privacy Officer of Irondequoit Ambulance immediately.

I also understand that I may be exposed to other confidential or proprietary information of Irondequoit Ambulance and I agree not to reveal any of that information to anyone at any time.

In addition, I understand that a breach of patient confidentiality may result in immediate suspension or termination as a member/employee of Irondequoit Ambulance. Upon termination of this privilege for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession. As a general rule, I understand that any patient or confidential information that I see or hear while a member/employee of Irondequoit Ambulance will stay here when I leave.

I acknowledge that I have completed and understand the HIPAA overview training on the privacy policies and procedures and have been given access to review those policies. I agree to abide by all policies or my membership or employment at Irondequoit Ambulance will be terminated.

Signature: _____ Date: _____

Print Name: _____

Witness: _____

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Please initial and date next to each item confirming receipt of each item below.

SOG's Initial: _____ Date: _____

Career Staff Manual Initial: _____ Date: _____

MLREMS Protocols Initial: _____ Date: _____

Internet Usage Policy Initial: _____ Date: _____

Misc./Additional Items:

_____ Initial: _____ Date: _____

_____ Initial: _____ Date: _____

_____ Initial: _____ Date: _____

_____ Initial: _____ Date: _____

_____ Initial: _____ Date: _____

_____ Initial: _____ Date: _____

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This application is to be placed in the members/employees personnel file. The following information is to be present with this document in order to be considered complete.

1. Pages 1-11 of this packet.
2. Pages 5, 7, 8, 9, 10, must be signed by applicant.
3. Page 11 is to be initialed and dated as each item is received by the member/employee
4. Copy of the criminal background check.
5. Copy of the driving records check.

Membership/Employment application
revised Oct. 2010. CT v1.0

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