Smithsburg Emergency Medical Services, Inc.

P.O. Box 411
Smithsburg, Maryland 21783

Web: www.SEMS79.org
Phone: 301.824.3314
Fax: 888.557.6158

Membership Application

Revised October 23, 2015

Instructions: This application must be completed in the applicant's own handwriting. All questions must be answered completely. Applicants must be at least 18 years of age to be considered for membership. A photocopy of the applicant's driver's license or other government photo ID as well as a photocopy of the applicant's social security card must be returned with this application.

Application Date: _____

Circle membership classification requested: Operational or Administrative

Full Name: _____DOB: _____

Last First Middle

Address: _____ Age: ____ Sex: _____

_____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email_____

Emergency Contact: _____ Phone: _____

Have you ever been a member or applied for membership with Smithsburg EMS before? If yes, provide dates and reason for leaving.

_____
_____
_____

How did you hear about us?

_____
_____
_____

Do you have any physical limitations? If yes, please explain.

_____
_____
_____

Are you allergic to anything including any medications? If yes, please explain.

_____
_____
_____

Have you ever been charged with, convicted of, pled guilty to, or not been found innocent of any crime for which you have been charged with other than a traffic violation? If yes, please explain in detail. A conviction will not necessarily preclude you from membership; however, non-disclosure likely will.

_____
_____
_____

Do you have any traffic violations other than parking tickets? If yes, please explain.

_____
_____
_____

Education

Grammar School: _____ Graduated? _____

Address: _____

High School: _____ Graduated? _____

Address: _____

College: _____ Graduated? _____

Address: _____

College_____ Graduated? _____

Address: _____

Career Information

Please list your employers, past and present, for the past 5 years. If you do not have enough room, please use the back of this form.

Employer: ____

Address: ____

Business Phone: _____________________   Title: ________________________

Name of Supervisor: ___________________________   Extension: ____________

Hours per Week: ________   Days per Week: __________   Currently Employed: ______

Employed from: __________ to ____________

If not currently employed, please list reasons for leaving. If terminated, please indicate as such.

____

____

Employer: ____

Address: ____

Business Phone: _____________________   Title: ________________________

Name of Supervisor: ___________________________   Extension: ____________

Hours per Week: ________   Days per Week: __________   Currently Employed: ______

Employed from: __________ to ____________

If not currently employed, please list reasons for leaving. If terminated, please indicate as such.

____

____

Employer: ____

Address: ____

Business Phone: _____________________   Title: ________________________

Name of Supervisor: ___________________________   Extension: ____________

Hours per Week: ________   Days per Week: __________   Currently Employed: ______

Employed from: __________ to ____________

If not currently employed, please list reasons for leaving. If terminated, please indicate as such.

____

____

Training

Please list any specialized training you may have, including expiration dates where appropriate. Any course not provided by the Maryland Fire and Rescue Institute or the American Heart Association should be indicated appropriately.

_____
_____
_____
_____
_____
_____

Please list any Fire, Rescue, or EMS companies that you are presently a member of, or have been in the past. Please indicate the month and year you joined. If applicable, indicate the month and year your participation ended, as well as relevant circumstances behind your departure.

_____
_____
_____
_____
_____
_____

References

Please provide three references not living in the same household with you.

Name: _____ Relationship: _____

Address_____ Phone Number: _____

_____

Name: _____ Relationship: _____

Address_____ Phone Number: _____

_____

Name: _____ Relationship: _____

Address_____ Phone Number:_____

_____

Agreement

I hereby affirm that all statements made herein are true and correct to the best of my knowledge. I authorize Smithsburg Emergency Medical Service (SEMS) to conduct whatever investigation they deem necessary to confirm statements submitted on this application. If the investigation determines any untrue statements are made, I understand this may be grounds for immediate termination, regardless of when this information surfaces.

I authorize SEMS and also request each current or former member, person, firm, or corporation I have provided as a reference to answer any and all questions that may be asked in connection with this application.

I hereby agree to submit myself upon request for a physical examination by an occupational medical facility selected by SEMS and understand that membership is subject to meeting medical standards. In addition, if accepted for membership I hereby agree to abide by the bylaws, rules and policies of SEMS.

I agree to submit myself within 21 days of being accepted into the membership for a hair sample drug screening as described by SEMS policy. I understand SEMS policy requires random drug and alcohol screening as well as drug and alcohol screening for reasonable suspicion.

I understand that SEMS operates 24 hours a day, 365 days a year to provide quality patient care. I further understand that my obligation for membership is 24 hours of service each month. In addition to the service requirement, I understand to maintain voting privileges at meetings of the membership I must attend 4 of the last 12 monthly membership meetings.

I understand that any and all information obtained by SEMS will become part of my personnel file and reasonable effort will be made to keep this information confidential.

I understand that SEMS will not discriminate against age, sex, religion, race, physical disability, or national origin, and will reasonably accommodate physically handicapped individuals.

I understand that nothing contained in this application is intended to create a contract between SEMS and myself for membership or to provide any benefit. No promises regarding membership have been made to me. If a membership relationship is established, I understand that my membership will be at will, and that either SEMS or I have the right to terminate my membership at any time, for any reason.

I understand that I must maintain current American Heart Association BLS for Healthcare Providers certification. I also understand that SEMS strongly encourages my enrollment in a Maryland EMT-B course as soon as possible. It will be my goal within 18 months to be certified as a Maryland EMT-B. I also understand that riding privileges may be contingent on other local, state, or Federal training standards, as well as other standards as determined by SEMS policy.

Initials:_____

I agree that in the case I hold a current driver's license I will provide a certified copy of my driving record before I may drive company vehicles. I further understand driving of company vehicles, both emergency and nonemergency, is always at the discretion of the officers and may be subject to certain limitations.

I understand that in the event I am charged with, convicted of, plead guilty to, or not been found innocent of any crime for which I have been charged, including any traffic violation, it is my responsibility to provide written notice of such within 14 days to a chief officer. Additionally, I understand that failure to report this information will result in disciplinary action, up to and including termination.

I understand that any materials, patches, badges, or identification of any kind will not be worn or displayed after the termination of membership with SEMS. Additionally, any items deemed property of SEMS must be promptly returned to a chief officer or I will face prosecution. Items I have purchased from the company by returned for reimbursement according to their condition.

I understand that it is my responsibility to keep personnel and training records accurate. I will notify SEMS within 14 days of any change of address, telephone number, marital status, etc. I will provide copies of all certification cards and/or certificates for my file as soon as possible upon completion of each course.

Signature:_____

Printed Name:_____ Date:_____

IF APPLICANT IS A MINOR, THE FOLLOWING MUST BE COMPLETED.

Guardian's Signature:_____

Guardian's Printed Name: _____ Date:_____

DO NOT WRITE BELOW THIS LINE

Date Voted: _____

Number of Votes (Yes/No):_____

Interviewed by:_____

Interview Date:_____

Background check completed by:_____
date:_____