Dear Prospective Applicant:

Thank you for your interest in joining the Stratford Emergency Medical Service. In order to process your application, please be sure all paperwork has been completed and appropriate copies are enclosed with your returned application to Stratford EMS. The following is a list of such documents:

- Copy of your valid drivers license
- Copies of all current certifications
- Release for Background form completed and signed
- EMS Observer Waiver Release form completed and signed by you and your physician

Once this completed information is received, the EMS Department will forward to Human Resource for processing. Upon clearing your background check, you will be contacted to set up an observation ride time on the ambulance. We look forward to helping you begin a rewarding experience with Stratford EMS.

Please call the EMS Administrative office if you have any questions.

2712 Main Street Stratford, CT 06615

Office: (203) 385-4060

TOWN OF STRATFORD
STRATFORD EMERGENCY MEDICAL SERVICE
EMS Administration, 2712 Main Street, Stratford, CT 06615

APPLICATION FOR VOLUNTEER SERVICE

THE TOWN IS AN EQUAL OPPORTUNITY EMPLOYER, DEDICATED TO A POLICY OF NONDISCRIMINATION IN EMPLOYMENT ON ANY BASIS PROHIBITED BY LAW.

PERSONAL INFORMATION:

TODAY'S DATE: ____________________

NAME: ____ SOCIAL SECURITY #: XXX – XX – ___ ___ ___ ___
LAST FIRST MIDDLE

PRESENT ADDRESS: ____
NUMBER STREET CITY STATE ZIP

PERMANENT ADDRESS: ____
NUMBER STREET CITY STATE ZIP

TELEPHONES: HOME: ____________________ WORK: ____________________ CELL: ____________________

ARE YOU 18 YEARS OLD OR OLDER? ☐ YES ☐ NO EMAIL ADDRESS: ____________________________

ARE YOU EITHER A US CITIZEN OR AN ALIEN AUTHORIZED TO WORK IN THE UNITED STATES? ☐ YES ☐ NO

ENTER YOUR CONNECTICUT DRIVER'S LICENSE NUMBER: ____________________________

HAVE YOU EVER COMPLETED AN APPLICATION TO THIS DEPARTMENT IN THE PAST? ☐ YES ☐ NO

CURRENT CERTIFICATION(S): Please check current certifications you hold.

☐ MRT ☐ EMT ☐ EMT-I ☐ EMT-P ☐ EMS-I ☐ CPR-I ☐ ACLS-I ☐ PALS-I

STATE OF CONNECTICUT CERTIFICATION #____________________ EXPIRATION DATE____________________

OTHER CERTIFICATIONS HELD____

EDUCATION & TRAINING:

SCHOOL (HIGH SCHOOL / COLLEGE):	LOCATION OF SCHOOL	# OF YEARS ATTENDED	DID YOU GRADUATE

U.S. MILITARY/NAVAL SERVICE: ☐ YES ☐ NO RANK: __________ PRESENT NAT.GUARD/RESERVES? _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEANOR? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:

DO YOU HAVE FRIENDS/RELATIVES VOLUNTEERING HERE? ☐ YES ☐ NO IF YES, PLEASE LIST NAMES:

EMPLOYMENT AND/ OR VOLUNTEER SERVICE HISTORY:

DATE/MONTH/YEAR	NAME/ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM: __________ TO:				
FROM: __________ TO:				
FROM: __________ TO:				
FROM: __________ TO:				

REFERENCES:

Personal Reference Release

List two personal references of supervisors you have worked with in previous volunteer services or paid employment:

NAME: ____________________ AGENCY: ________________________ TELEPHONE: ______________

RELATIONSHIP: ____

NAME: ____________________ AGENCY: ________________________ TELEPHONE: ______________

RELATIONSHIP: ____

I understand that each will be contacted by Stratford EMS. I agree to telephone each and provide permission for my volunteer/employment history and personal references to be discussed.

APPLICANT: ________________________________ DATE OF BIRTH: ______________

SIGNATURE: ________________________________ DATE: ____________________

WITNESS: __________________________________ DATE: ____________________

INVITATION TO SELF IDENTIFICATION FOR PERSONS WITH DISABILITIES,
SPECIAL DISABLED VETERANS OF THE VIETNAM ERA

The Town is a recipient of Federal funds, subject to requirements of the Vietnam Era Veterans Readjustment Act of 1974, as amended (38 USC 2012), and to the requirements of Section 503 of the Rehabilitation Act of 1973, as amended, as well as The Americans with Disabilities Act and their implementing regulations. These Acts and regulations require that the Town take affirmative action to employ (volunteer), and to advance in employment (volunteer service), qualified persons with disabilities, special disabled veterans, and veterans of the Vietnam era.

If you are a person with a disability, a special disabled veteran, or a veteran of the Vietnam era, and would like to be considered under the Affirmative Action Program, please tell us. Provision of this information is voluntary. If you do not wish to identify yourself at this time as a person with a disability, a special disabled veteran, or a veteran of the Vietnam era, you will not be subject to any adverse treatment. If you wish to identify yourself, the information provided will be used in accordance with the Acts and regulations. This means that the information provided will be:

1. Kept confidential, except that:
   a. Supervisors and managers may be informed of any restrictions on work or duties of persons with disabilities or special disabled veterans, and of any necessary accommodations.
   b. First aid and safety personnel may be informed when and to the extent appropriate, if a particular disability may require emergency treatment.
   c. Government officials investigating compliance with the Acts will be informed.
2. Used only in accordance with the Acts and their implementing regulations.
3. Used to ensure proper placement. In order to assist us in making proper placement, we ask that if you have a disability which might affect your job performance or create a hazard to you or to others in connection with the job for which you are applying, you tell us the following:
   a. What skills and/or procedures you use or intend to use to perform the job notwithstanding the disability.
   b. What accommodations we could make which would enable you to perform the job properly and safely. These might include special equipment, changes in the physical layout of the job, elimination of certain non-essential duties, or other accommodations.

TO BE FILLED OUT BY APPLICANT OR EMPLOYEE:

I certify that I have read the above "INVITATION TO SELF IDENTIFICATION" and that I understand its terms. I further attest, by checking the appropriate block and signing below, that I am:

☐ Person with a disability. ☐ Special disabled veteran. ☐ Veteran of the Vietnam era. ☐ None of these.

SIGNATURE: ______________________ PLEASE PRINT: ________________________ DATE: _____________

VOLUNTEER CERTIFICATIONS AND AGREEMENTS:

I understand that a positive and properly confirmed drug test for controlled substances or refusal to submit to a drug test is grounds for denial or termination of volunteer position.

I authorize representatives of the Town of Stratford to obtain pertinent information from my previous background including a criminal records check. I authorize my previous volunteer agencies or employers, references, and persons with knowledge of my work history and background to provide pertinent information to the Town of Stratford and hereby release all such persons and waive any claims, demands or causes of action whatsoever, in connection with the request for and release of such information.

I certify that the information on this application is true and complete to the best of my knowledge. I understand that any willful omissions or falsifications will be reason for withdrawal of a volunteer position offer or termination of my volunteer membership whenever the omission or falsehood is discovered. I authorize any investigation into the statements I have made in this application as necessary to arrive at any decision on my volunteer membership.

All part-time employees/volunteers of the Town of Stratford have the right to resign from their position at any time, or any reason or for no reasons at all, with or without advance notice. The Town of Stratford retains the same right with respect to termination of any employee/volunteer's position. No manager, supervisor or other individual at the Town of Stratford has authority to make a commitment of guaranteed or continuing employment/volunteer opportunity to you, and no document or publication of the Town of Stratford should be interpreted to make such a guarantee. NOTHING STATED BY THE TOWN OF STRATFORD, IN WRITING OR ORALLY, DURING THE INTERVIEW PROCESS IS TO BE CONSTRUED AS CREATING A CONTRACT BETWEEN THE APPLICANT AND THE TOWN OF STRATFORD.

I have read, and understand and agree to the foregoing.

______________________________ ______________________

Signature of Applicant Date

TOWN OF STRATFORD
VACCINATION DECLINATION FORM

MEMBER/APPLICANT'S NAME: ______________________________

I understand that due to my occupational exposure to blood or other potential 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. 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/Applicant Signature Date

______________________________ ______________
Representative Signature Date

DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED BY EMS STAFF

DATE APPLICATION RECEIVED: ______________ DATE OF INTERVIEW: ______________

- ☐ General Service Information (volunteer, established 1977, activities, etc,)
- ☐ Probationary Period (3 months).
- ☐ Monthly hour requirement.
- ☐ Verification of application including criminal record check.
- ☐ Physical and drug screening required of all applicants. Once you are notified, you must report for physical within 48 hours.
- ☐ Bloodborne Pathogen Awareness training requirement.

SIGNATURE OF INTERVIEWER:______________________________ DATE:______________

TOWN OF STRATFORD

RELEASE FOR BACKGROUND INFORMATION

Last Name	First Name	M.I.
Address		
City, State, Zip		
Social Security #		
Date of Birth		
Position Applied For		

In connection with my application for employment, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies, former employers, Department of Motor Vehicle and the Military Services to release information they may have about me to the person or company with which this form has been filed, or their agent, and release them from an liability and responsibility from doing so. I also authorize the procurement of an investigative consumer report and understand that it may contain information about my background, mode of living, character and personal reputation. This authorization, in original or copy form, shall be valid for this and any further reports or updates that may be requested. Further information may be available upon written request within a reasonable period of time.

Applicant's Signature

Date

TOWN OF STRATFORD
VOLUNTEER APPLICANT

Volunteer Name (Print): ______________________________
FIRST MI LAST

Address: ______________________________

City: ____________ State: ________ Zip: ________

This is to certify that I have examined the above named person and found him/her to be in good health and free from medical or emotional illness or disorder or addiction that would currently pose a risk to adults and/or children in care or interfere with effective functioning as a volunteer in a Town sponsored program.

Signature of Physician*: ______________ Date of Visit: ________

Name of Physician (Print) : ______________________________

Address: ______________ Phone Number: ________

City: ____________ State: ________ Zip: ________

List any special accommodations/conditions or limitations below:

____

____

____

*This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.

STRATFORD EMS OBSERVER WAIVER

In consideration of the benefits to be derived from participation in observing with Stratford EMS, the undersigned does hereby release and discharge Stratford Emergency Medical Service and the Town of Stratford, and any officer, employee, volunteer or member of said entities from any and all claim or damage which may arise out of or from the participation by said EMS Observer with Stratford Emergency Medical Service, including but not limited to responding to emergency calls with Stratford Emergency Medical Service.

Signature: ______________ Date: ________