



Rock Valley Ambulance Association



Application for Membership

Name:

Address:

Telephone – Home: Work: Cell:

Email:

Occupation: Employer:

Birth Date: Soc. Sec. Number:

Highest Level of Education Completed:

Do you possess a valid driver's license to operate a vehicle in Iowa? ☐ Yes ☐ No

Are you state certified in Iowa as an Emergency Medical Technician? ☐ Yes ☐ No

Have you completed an Iowa state-approved First Responder Course? ☐ Yes ☐ No

Has any jurisdiction suspended, revoked, or limited a license issued to you? ☐ Yes ☐ No

If yes, include jurisdiction, date, location, reasons and current status:

If you are not state certified or have not completed the above, you would be required to become certified and/or complete such courses as soon possible upon becoming a member of the Association. Fees for training and certification may be charged to you under circumstances if courses and/or certification are not completed.

Have you ever been convicted of, found guilty of, or entered a plea of no contest to a felony or misdemeanor crime? (other than minor traffic violations) ☐ Yes ☐ No

If yes, include date, location, charge, court disposition, and current status for each charge:

Is there any reason, condition, and/or concern which the Association should be made aware of which you would anticipate may impact the Association's decision to accept your application? ☐ Yes ☐ No

If yes, please explain here:

Shifts run from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. Members must take 2 to 3 shifts per week. Please state your shift preference:

Will you be able to arrive at the ambulance garage within 3-4 minutes from the initial page? ☐ Yes ☐ No

List three references. Please give their address and telephone number and state what affiliation you have had with them. Do not list relatives.

1) Name:

Address:

Telephone Number:

Affiliation:

2) Name:

Address:

Telephone Number:

Affiliation:

3) Name:

Address:

Telephone Number:

Affiliation:

I hereby affirm that the information provided on this application is true and correct to the best of my knowledge. I understand that I am required to update my answers or information submitted to the Association should the same change. I consent to any reasonable inquiry that may be necessary to verify or clarify the information I provided.

Date:

Signature of Applicant:

***If under the age of 18, this application must be signed by a parent or legal guardian.**

Date:

Signature of Parent or Legal Guardian:

All applications are subject to squad approval

Please return application to the following address:

Or email application to:

Rock Valley Ambulance Association
P.O. Box 52
Rock Valley, IA 51247

rvems@cityofrockvalley.com