

# Wolcott Volunteer Ambulance Association

P.O. Box 6066  
WOLCOTT, CT 06716

OFFICE: (203) 879-4122  
FAX: (203) 879-5420



## WELCOME

Prospective Member:

Thank you for your interest in Wolcott Volunteer Ambulance Association. WVAA is a combination paid / volunteer organization that provides emergency medical services for the Town of Wolcott. The backbone of our membership is made up of volunteer EMTs and Paramedics from all over the greater Waterbury area. Volunteerism can be difficult for those with busy lives. Therefore we ask that you give great thought about this before you submit this application.

Please fill out the attached application in entirety. All of the information that you provide will be kept confidential and will not be released to any third-party organizations. You will need to sign the bottom of the application before it will be processed and attach copies of your EMT license or certification as well as any other certifications that you may have. In addition, we will complete a background check on every prospective applicant. Please fill out the Release Authorization Form so that this can be completed. Upon acceptance, you will undergo a complete physical and drug screening prior to employment. Any and all cost associated with this will be the responsibility of WVAA.

Our application process typically takes 2-4 weeks from receipt of the application to acceptance into the organization. Applications can be mailed back to:

Wolcott Vol. Ambulance Assoc.  
Attn: Applications  
PO Box 6066  
Wolcott, CT 06716

I look forward to working with you. Please feel free to call or email me with any questions or concerns.

Sincerely,

Matt Howard, EMT-P  
Deputy Chief  
Wolcott Vol. Ambulance Assoc.  
(203)879-4122 Ext. 21  
matt.howard@wolcottambulance.com  
www.wolcottambulance.com

*"CONCERN FOR OTHERS"*

# Wolcott Volunteer Ambulance Association

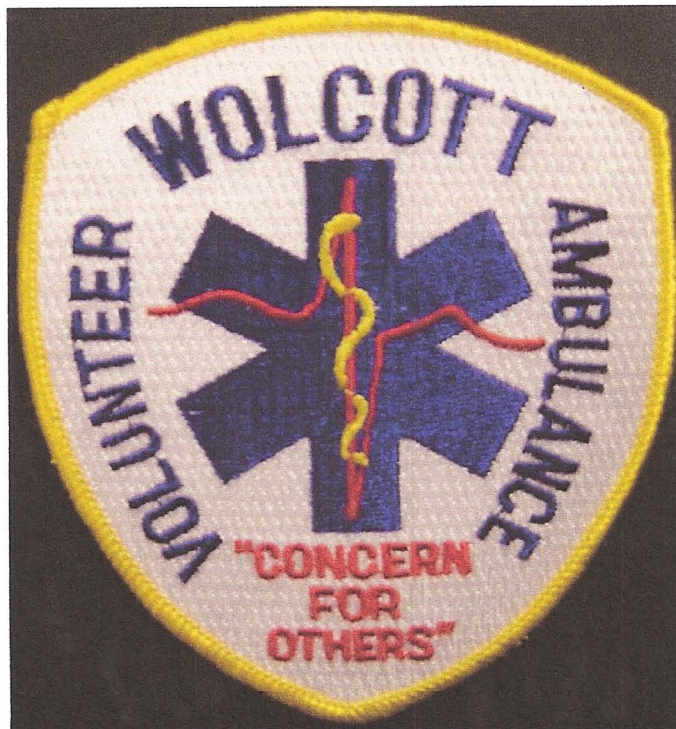
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## General Requirements for Membership

- Applicant must be a State of Connecticut certified EMT-B, EMT-I or EMT-Paramedic. Students may apply however acceptance will be dependent upon completion of an EMT class and certification by the State of Connecticut.
- Applicant must be able to pass a medical examination and drug test.
- Applicant must have no criminal history. All applicants will be put through a criminal background check.
- All new members will be required to volunteer a minimum of 24 hours per month during their probationary period of 6 months or 144 hours total. Once their probationary period is completed, the member is required to volunteer a minimum of 12 hours per month.
- All new members will be required to attend all WVAA meetings and training sessions during their probationary period.
- Town of Wolcott residency is not required.



*"CONCERN FOR OTHERS"*



# *Wolcott Volunteer Ambulance Association*

[www.wolcottambulance.com](http://www.wolcottambulance.com)

Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (     ) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Are you a US Citizen? Yes / No if No, explain: \_\_\_\_\_

Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

Have you ever had your license suspended or revoked? Y / N

Current Employer: Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

May we contact your employer? Yes / No

Highest level of education attained: \_\_\_\_\_

What is your current level of certification: Student  EMT-B  EMT-I  EMT-P  Cert Num \_\_\_\_\_

Have you had: HAZMAT Awareness: Y / N  
CEVO: Y / N

Hepatitis B vaccine: Y / N  
CPR: Y / N

List any other skills or certifications:  
\_\_\_\_\_

Have you ever applied here before? Y / N If yes, when: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

What hours would you be committed to volunteer if you are accepted?

Weekdays: \_\_\_ 6am-6pm \_\_\_ 6pm- 11pm \_\_\_ 11pm – 6am

Saturdays: \_\_\_ 6am-2pm \_\_\_ 2pm-10pm \_\_\_ 10pm-6am

Sundays: \_\_\_ 6am-2pm \_\_\_ 2pm-10pm \_\_\_ 10pm-6am

Are you or have you ever been a member of another EMS organization? If so, please list the organization and your supervisor.

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How many years of EMS experience do you have? \_\_\_\_\_

How did you learn about WVAA? \_\_\_\_\_

Have you ever been convicted of a crime? Y / N

If yes, explain in detail (attach any supplemental documents):

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Have you ever been known by a different name or alias? Y / N If so, please list all other names.

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List two (2) references that are not members of WVAA:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Previous addresses: 1. \_\_\_\_\_ City: \_\_\_\_\_

2. \_\_\_\_\_ City: \_\_\_\_\_

3. \_\_\_\_\_ City: \_\_\_\_\_

**THE STATEMENTS THAT I HAVE MADE ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE STATEMENTS WILL IMMEDIATELY DISQUALIFY MY APPLICATION. I ALSO UNDERSTAND THAT IF I AM ACCEPTED AS A MEMBER, I WILL SERVE A PROBATIONARY PERIOD OF NO LESS THAN SIX (6) MONTHS OR 144 HOURS OF SERVICE. DURING MY PROBATION SHOULD I BE EJECTED, SUSPENDED, OR DISCIPLINED IN ANY WAY, I HAVE NO RECOURSE TO APPEAL TO THE MEMBERSHIP, THE EXECUTIVE OFFICERS, OR ANY SINGLE MEMBER TO HAVE SUCH ACTIONS REVERSED. I FULLY UNDERSTAND THAT I MUST VOLUNTEER AT LEAST TWENTY (20) HOURS PER MONTH OF ON DUTY TIME TO THE CORPS EACH MONTH. I UNDERSTAND THAT I MUST PASS A BACKGROUND CHECK IN ORDER TO BE CONSIDERED FOR MEMBERSHIP. WVAA WITHHOLDS THE RIGHT TO REFUSE EMPLOYMENT TO ANY PARTY WHO FAILS CRIMINAL BACKGROUND OR DRUG TESTING. AFTER COMPLETING MY PROBATIONARY PERIOD, I MAY SEEK REIMBURSEMENT FOR UNIFORMS AND TRAINING AFTER SUBMITTING PROOF OF PURCHASE. I HEREBY AUTHORIZE THE ASSOCIATION TO CHECK THE INFORMATION HEREIN.**

Applications Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Administrative Use Only:**

Date application received: \_\_\_\_\_ Received by: \_\_\_\_\_  
Confirmation letter sent by: \_\_\_\_\_ Date letter sent: \_\_\_\_\_  
Meeting date: \_\_\_\_\_ Quarterly meeting / Board of Director's Meeting / Chief's Meeting  
Application results: Accepted \_\_\_\_\_ Denied \_\_\_\_\_ Tabled \_\_\_\_\_  
Reason for Table or Deny \_\_\_\_\_  
Notification Date: \_\_\_\_\_ Physical Date: \_\_\_\_\_ Orientation Date: \_\_\_\_\_  
Comments: \_\_\_\_\_



## Release Authorization

Applicant Complete The Following

I. In connection with my application for employment/membership, I understand that a consumer report or an investigative consumer report may be requested that will include information as to my character, work habits, performance and experience, along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job described, you may be requesting information from public and private sources about my: worker's compensation injuries, driving record, court record, education, credentials, credit, and references. If company policy requires, I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.

II. Medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a Consumer Reporting Agency. If so, I will be notified and given the name and address of the agency or the source that provided the information.

III. I acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original. This release is valid for most federal, state and county agencies including the Minnesota Department of Labor.

IV. Minnesota, Oklahoma, and California applicant only: If you want a copy of the report(s) ordered, Check this box . The report(s) will be sent by the reporting agency to you at the address below.

V. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by **Wolcott Volunteer Ambulance Assoc, Inc.** or its agent, to furnish the information described in Section 1.

VI. I hereby authorize release of information from my Department of Transportation regulated drug and alcohol testing records by my previous employer to **Wolcott Volunteer Ambulance Assoc, Inc.** This release is in accordance with DOT Regulation 49 CFR Part 40, Section 40.25. I understand that information to be released by my previous employer is limited to the following DOT-regulated items: alcohol tests with a result of .004 or higher, verified positive drug tests, refusals to be tested, other violations of DOT agency drug and alcohol testing regulations, information obtained from previous employers of a drug and alcohol rule violation and any documentation of completion of the return-to-duty process following a rule violation.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes. I hereby release the employer and the agents and all persons, agencies, and entities providing information or reports about me and all liability arising out of the requests for or release of any of the above mentioned information or reports.

|   |                                |                                 |                                   |   |
|---|--------------------------------|---------------------------------|-----------------------------------|---|
| Please print your full name   |                                | Last                            | First                             | Middle  |
| Please print other names you have used  |                                |                                 |                                   |   |
| Home Address  |                                |                                 |                                   |   |
| City  |                                | State                           | Zip Code                          |   |
| Social Security Number  |                                |                                 | Date of Birth                     |   |
| The following states require sex and race to obtain information: AL, AR, FL, GA, IA, IL, IN, MI, OR, TX, WI |                                |                                 |                                   |   |
| Sex   | <input type="checkbox"/> Male  | <input type="checkbox"/> Female |                                   |   |
| Race  | <input type="checkbox"/> Asian | <input type="checkbox"/> Black  | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Caucasian <input type="checkbox"/> Other |
| Driver's License Number   |                                | State Issuing License           |                                   |   |
| Name as it appears on license   |                                |                                 |                                   |   |
| Signature   |                                |                                 | Today's Date                      |   |