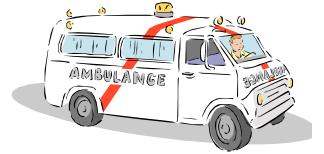


VALHALLA AMBULANCE CORPS
 P.O. Box 14
 VALHALLA, NY 10595



APPLICATION FOR VOLUNTEER MEMBERSHIP

Date of Application: _____ Referred By: _____

PERSONAL DATA

Name: _____ Date of Birth: _____

Street: _____ Social Sec. #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Driver's License ID #: _____ Exp. Date: _____

EMPLOYMENT

Employer: _____ Type of Business: _____

Street: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

EDUCATION

High School Attended: _____ Year Graduated: _____

College Attended: _____ Year Graduated: _____

Major: _____ Licenses or Certifications (please enclose copies):

EMT First Responder CPR First Aid Other: _____

List any previous EMS experience:

REFERENCES

Name: _____ Occupation: _____ Phone: _____

Name: _____ Occupation: _____ Phone: _____

SCHEDULE

Position Desired: ___ EMT ___ Driver ___ Assistant

What days/nights and hours are you available to serve?
