



# Village Ambulance Service



Community Education & Training Programs

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## APPLICATION FOR ADMISSION EMT-Basic Program

**INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED**

*PLEASE PRINT LEGIBLY*

Training Program Applying For:

EMT-Basic     EMT-Intermediate

Winter Program 20\_\_\_\_\_     Spring Program 20\_\_\_\_\_

Summer Program 20\_\_\_\_\_     Fall Program 20\_\_\_\_\_

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**Demographic Information:**

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

Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_@\_\_\_\_\_

Place of Employment: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer's Telephone: (    ) \_\_\_\_\_ Ext: \_\_\_\_\_

Have you ever enrolled in a training program or continuing education session with Village Ambulance Service Community Education and Training Programs before?

If yes, list program(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever pled “guilty” or “no contest” to, or been convicted of a crime?  
**If yes you may be unable to sit for the Massachusetts certification exam**

If yes, please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Educational Background:**

Level of Education	Number of Years Completed	Did you Graduate?	Course of Study	Degree Received
High School or G.E.D				
College (Graduate)				
College (Undergraduate)				
Prior EMT Program	What Year?	Completed? Y or N	Instructor	
Other				

**References (minimum of 3 required):**

Name:	Relation:	Phone:	# of years known

**Current Certifications/Licenses Held:**

Certifications:

Expiration Date:

[ ] C.P.R: \_\_\_\_\_

[ ] EMT- B (ALS Program Only): \_\_\_\_\_

[ ] Driver's license: \_\_\_\_\_

[ ] Other: \_\_\_\_\_

**Please affix a current copy of your Motor Vehicle Driver's License (REQUIRED)**

Front of Driver's License	Back of Driver's License

**Please affix a current copy of your CPR CARD (OPTIONAL)**

Front of CPR CARD	Back of CPR CARD

Upon completion of this application, please mail or fax the application to:

**Village Ambulance Service**  
**Attn: Shawn Godfrey, NREMT-P, I/C**  
**30 Water Street**  
**Williamstown, MA 01267**  
**Phone: (413) 458-4889**  
**Fax: (413) 458-8476**

**DEADLINE FOR APPLICATION IS FEBRUARY 15, 2012**

Village Ambulance Service community education and training programs does not unlawfully discriminate on the basis of age, race, national origin/ancestry, color, sex, religion/creed, or handicap/disability. Village Ambulance Service Community Education and Training Programs operates in accordance with applicable laws on equal opportunity and non-discrimination in the consideration for admission.

**I hereby certify that to the best of my knowledge the information furnished on this form is true and complete without evasion or misrepresentation. I understand that if found to be otherwise, it is sufficient cause for rejection and/or dismissal.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Program Use Only**

Date application received:	Complete: yes no	Method of Payment:
Student ID Number:	Processed:	Amount Received:

## Optional Participant Health Form

### Disclosure

Village Ambulance Service training programs may involve a variety of activities including warm-ups, group initiative problems, and hands on application of practical skills training. These activities are designed to be within the limits of a person who is in reasonable good health. The level of participation in all programs and activities is at all times completely up to the individual.

Safety is a high priority in all programs. In addition, each participant must assume the risk that he or she may suffer an emotional or physical injury and disability. Each participant must have health/accident insurance coverage. The information requested on this form is intended to help alert staff to pre-existing medical conditions. This information will be held in confidence. Please complete the form below and return it with your application.

### General/Medical Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Do you have health/medical insurance? ..... no yes

Name & Address of Company: \_\_\_\_\_  
\_\_\_\_\_

Do you have any limiting physical or health disabilities - temporary or permanent - that you or your doctor feel would limit your participation in a Village Ambulance Service activity?..... no yes

Do you have any chronic or recurring injuries? ..... no yes

Are you currently taking any medication? ..... no yes

Have you had surgery in the past year for any condition which may limit your participation? ... no yes

Do you have asthma? ..... no yes

Do you have diabetes? ..... no yes

If yes to any of the above, please explain/describe:

\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant? ..... no yes

Do you have or do you have a history of:

\_\_\_\_\_ High blood pressure      \_\_\_\_\_ Currently on medication for high blood pressure

\_\_\_\_\_ Heart palpitations      \_\_\_\_\_ Chest pain or pressure      \_\_\_\_\_ Stroke

\_\_\_\_\_ Heart attack      \_\_\_\_\_ Heart disease      \_\_\_\_\_ Heart murmur

If yes to any of the above, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any other concerns or conditions that may affect your participation:

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**We strongly recommend that you consult your physician or midwife if you are pregnant or have checked off any of the conditions above before participating in any Village Ambulance Service EMS training activity.**

**Emergency Contact Information**

Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

## **Participant Agreement, Release, and Assumption of Risk**

In consideration of the services of Village Ambulance Service Community Education and Training Programs., their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "VAS"), I hereby agree to release, indemnify, and discharge VAS, on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that my participation in group initiatives, problem solving exercises and personal or professional growth and development training, including clinical and field experiences for EMT students, entails known and unanticipated risks that could result in physical or emotional injury or death. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

**The risks may include, among other things:** Strenuous physical activity; slips and falls; sprains, strains; inclement weather; other participants and/or my own negligence; and emotional stress.

Furthermore, VAS facilitators have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They may give inadequate warnings or instructions, and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless VAS from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of VAS equipment or facilities.

4. Should VAS or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I understand that VAS does not provide health insurance for students of their courses. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

**By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against VAS on the basis of any claim from which I have released them herein. I also acknowledge that I have fully satisfied myself as to the nature of the activity or activities in which I will be participating, the risks associated with each such activity, and my responsibility to know my own limits. In the event of illness or injury, consent is hereby given to provide emergency medical care, hospitalization, or other treatment that may become necessary.**

**I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.**

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

Print Name: \_\_\_\_\_

**Parent or Guardian Additional Indemnification**  
(Must be completed for participants under the age of 18)

In consideration of \_\_\_\_\_(Minor) being permitted by VAS to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless VAS from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent /Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Photo/Media Release**

I grant Village Ambulance Service Community Education and Training Programs the right to use, reproduce, assign and/or distribute photographs, films, video tapes, and sound recordings of me for use in materials they may create.

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

Print Name: \_\_\_\_\_

Parent /Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Village Ambulance Service**  
Community Education and Training Programs



30 Water Street  
Williamstown, MA 01267  
Business: (413) 458-4889 Fax: (413) 458-8476

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**AUTHORIZATION TO REQUEST  
CRIMINAL OFFENDER RECORD INFORMATION**

Every applicant must complete a CORI authorization form prior to entering a program.

**APPLICANT INFORMATION:**

\_\_\_\_\_  
PRINT LAST NAME                      FIRST NAME                      MIDDLE INITIAL

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_/\_\_\_\_/\_\_\_\_

MOTHER'S MAIDEN NAME \_\_\_\_\_

SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_ FT. \_\_\_\_ IN. WEIGHT: \_\_\_\_\_ EYE COLOR \_\_\_\_\_

CURRENT ADDRESS: STREET \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

FORMER ADDRESS: STREET \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**PLEASE SIGN AND DATE THE STATEMENT BELOW:**

I, \_\_\_\_\_ hereby give permission to the  
Massachusetts Department of Public Health, Office of Emergency Medical Services to  
request my Criminal Offense Record Information (CORI). Date: \_\_\_\_\_