MARSING AMBULANCE SERVICE
PO Box 132
Marsing ID 83639
Fax: 208-896-5563
Phone: 208-740-2449
Email: jdphipps@marsingambulance.com

VOLUNTEER PERSONNEL AFFILIATION APPLICATION

DATE: _____

NAME: _____D O B_____

ADDRESS: _____ Length of time at this address: _____

CITY: _____STATE:_____ZIP:_____

Previous address if less than 1 year: _____

CITY: _____STATE:_____ZIP:_____

HOME PHONE: _____ WORK PHONE: _____CELL PHONE: _____

EMAIL: _____

SSN: _____DL#: _____ STATE: _____

Which position are you most interested in: ○ **EMT** ○ **DRIVER** ○ **Either/Both**

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Work Phone: _____

EMS History

Mark all that apply:

EMS Certification: _____Yes _____ No EMS Level _____ Issuing Authority: _____Expires: _____

Nurse Certification: _____ Yes _____ No Issuing Authority: _____Expires: _____

Doctor Certification: _____ Yes _____No Issuing Authority: _____Expires: _____

Recent EMS class: _____ Yes _____ No Passed ID State EMS tests: Written _____ Yes _____ NO
Practical _____ Yes _____ NO

Any other training or certifications related to Emergency Medical Services (CPR, Hazemat, EVOC, etc.)

_____

_____

_____

Do you have any physical limitations or medical conditions that would affect your ability to make decisions, perform patient care, drive, walk, run, lift, carry or hike? _____ Yes _____ No

If yes please explain:

_____

_____

_____

Why do you desire affiliation with Marsing Ambulance Service?

_____

_____

_____

_____

PREVIOUS/CURRENT EMS OR FIRE DEPARTMENT AFFILIATIONS:

Name of Service: _____

Address: _____City: _____State: _____Zip: _____

Supervisor Name: _____Phone: _____

Date of Affiliation: From_____ To: _____

Reason for Leaving: _____

_____

May We Contact: _____ Yes ____ No

Name of Service: _____

Address: _____ City: _____ State: _____ Zip: _____

Supervisor Name: _____Phone: _____

Date of Affiliation: From _____ To: _____

Reason for Leaving: _____

_____

May We Contact: _____ Yes _____ No

Have you ever been denied affiliation with, or had your affiliation revoked by an EMS service, fire department or police department? _____Yes_____ No If yes Explain: _____

_____

_____

_____

_____

_____

_____

Have you ever had your first responder or EMT certification revoked or suspended? _____Yes _____No If Yes, Explain:

_____

_____

_____

_____

HAVE YOU RECENTLY TAKEN AN EMT CLASS?

Name of school: _____

Address of School: _____ City: _____ State: _____ Zip: _____

Name of instructor: _____ Phone: _____ Email: _____

Have you passed Idaho State EMT testing? _____ Written: _____ Date: _____ Practical: _____ Date: _____

May we contact Yes _____ No _____

Have you ever been convicted of a felony? _____ Yes _____ No If yes, Explain: _____

_____

_____

_____

_____

_____

_____

Driving History

Do you have a current Idaho Driving license? _____ Yes _____ No

You will be required to provide Marsing Ambulance with a copy of driver's license and a copy of driving record for last 10 years, if you have not been in the state of ID for 10 years you will have to provide us with your driving record from the other states of residency.

Have you had any motor vehicle accidents in the last 5 years? _____Yes _____ No If yes Explain: _____

_____

_____

_____

Have you had any motor vehicle traffic violations in the last 3 years? _____Yes _____ No If yes Explain: _____

_____

_____

_____

Have you ever had your driving privileges revoked (in any state)? _____Yes _____ No If yes Explain: In what state

_____

_____

_____

PREVIOUS EMPLOYMENT:

Business Name: _____

Address: _____City: _____ State: _____Zip: _____

Supervisor Name: _____Phone:_____

Date of Employment: From: _____To: _____

Reason for Leaving: _____

_____

May We Contact: _____ Yes _____ No

Business Name: _____

Address: _____City: _____State: _____Zip: _____

Supervisor Name: _____Phone: _____

Date of Employment: From: _____To: _____

Reason for Leaving: _____

_____

May We Contact: _____ Yes _____ NO

PERSONAL REFERENCES:

Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____

Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____

Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____

I understand and agree to allow Marsing Ambulance Service and its representatives to perform a check on my background. This background check may include contact with my current and previous employers, previous affiliations, personal references, law enforcement agencies and driving records. Any false statements made on this application will be grounds for refusal of affiliation with Marsing Ambulance Service.

Signature of Applicant: _____ Date: _____