Closter Volunteer Ambulance and Rescue corps, Inc.

Serving Closter & Alpine since 1936

Cadet Application
(16 - 18 years old)

Name ______________________ S.S.# __________________________ Date __________

Address ____

Telephone No. ____________________ Birth date ______________________________

E Mail Address (please print) ____

Do you live in Closter or Alpine ______ If yes , how long ? ________

If no, what neighboring town to Closter do you live in ? ____________ How long? ____

Have you, or do you belong to an ambulance corps? (If so give details)

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Have you ever had any first aid training? (If so, give name of courses, where taken, and Expiration dates of certification cards)

____

What schools have you or are currently attending? Include technical schools if applicable.

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During what hours of the day and what days of the week would you be available for ambulance duty and Corps activities? ___________________________________

If employed who is your present employer ?________________What are your hours ?________

If accepted to membership under this application, I agree to comply with all orders, rules and regulations of the Corps.The answers to the above are true to the best of my knowledge and belief and I understand that any false statement on this application is sufficient cause for rejection or dismissal.

Signature ________________________________

Parent / Guardian signature ______________________________

Date applicant met with membership committee _______________
Signature of Committee representative ______________________
Date applicant admitted to Corps. ___________________________

TO BE COMPLETED BY PHYSICIAN

Past History

Heart________ Rupture________ Fainting spells_________

Tuberculosis_________ Kidneys______________

Habits: Alcohol __________ Drugs_______________

Other Unusual Medical History __________________________

Physical Findings

Height _______ Weight _______

Hernia _______ Vision _______

Hearing _______ Throat _______

Nose _________ Neck _________

Lungs _______ Abdomen ______

Heart _________ Blood pressure _____/_____

Extremities____

Recommendations ____

____

Hepatitis B Vaccination Record if applicable:

Dose Vaccination Date:

#1 _______

#2 _______

#3 _______

IS THERE ANY REASON WHY YOU FEEL THIS APPLICANT WOULD NOT BE ABLE TO TO SERVE AS A FULL ACTIVE MEMBER OF THE CLOSTER VOLUNTEER AMBULANCE AND RESCUE CORPS . ____

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Signed ____________________________
(Physician)

Address ____________________________

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Date ______________