



## DUANESBURG AMBULANCE

P.O. Box 130, 130 Cole Road  
Delanson NY 12053  
(518) 895-2200  
Fax (518) 895 2800

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Medical Applicants fill  
out full form

☐

Social Committee fill  
out part one & two

☐

Junior Volunteers fill out part one  
and parental authorization

### SERVING OUR NEIGHBORS 24 HOURS A DAY

#### Application for Membership / Social Committee

*Please complete and return application with membership dues of \$5.00*

##### Part One

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

NYS Drivers License # \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_

E-Mail \_\_\_\_\_

Desired Membership Status (*circle*)      Medical      Social Committee      Medical Support

##### Medical

Do you have a current CPR card? \_\_\_\_\_ Yes \_\_\_\_\_ No      Expiration Date: \_\_\_\_\_

NYS EMT / CFR:      EMT / CFR # \_\_\_\_\_      Expiration Date: \_\_\_\_\_

☐

Certified First Responder

☐

Basic

☐

Advanced

☐

Critical Care Tech

☐

Paramedic

Driving Courses \_\_\_\_\_

Other Medical Qualifications \_\_\_\_\_

Reason for wanting to join Duanesburg Ambulance: \_\_\_\_\_

Have you ever been arrested?

Yes No

Have you ever been convicted of a felony?

Yes No

Have you ever been convicted of a DWI or DWAI?

Yes No

If yes, please list date(s): \_\_\_\_\_

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**Part Two**

Membership Sponsor: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian / Parent Signature: \_\_\_\_\_

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**INTERNAL USE ONLY:**

Date Application Read at Membership or Annual Meeting \_\_\_\_\_

Drivers License Check Done by: \_\_\_\_\_ Date: \_\_\_\_\_

Three Month Probationary Period: Begin: \_\_\_\_\_ End: \_\_\_\_\_

Membership Vote Date: \_\_\_\_\_