



# Hawthorne Volunteer Ambulance Corps

## Membership Application

970 Goffle Road, Hawthorne, New Jersey 07506  
973-427-1818 / [Info@HawthorneEMS.org](mailto:Info@HawthorneEMS.org)  
[www.HawthorneEMS.org](http://www.HawthorneEMS.org)



Dear Applicant,

Thank you for expressing interest in the WILLIAM B. MAWHINNEY MEMORIAL AMBULANCE CORP INC. d/b/a Hawthorne Volunteer Ambulance Corps. There is a never ending need for volunteers. Members of the Corps respond to emergency calls 24 hours a day, 7 days a week, and 365 days a year.

There are several steps to our membership process. Your application needs to be filled out completely and accurately. After your application is submitted to the Corps' Officer's Committee, you will be called for an initial interview. This interview is non-formal and gives the Officer's Committee time to ask you a few questions and for you to ask us any questions that you might have. After the initial interview, your application will be sent out for a criminal background check. Once the background check has been received, the committee will review the data received and decide on a course of action for you. If you are accepted by the Officer's Committee, you will be called for a second interview. At that time you will be provided with all of your uniforms, equipment and additional paperwork.

Once you are a member, you will be placed on a 6 month probationary period in which you will have a chance to participate in drills, training, monthly meetings and most importantly, calls for assistance. You will be evaluated on your participation during this period, so be sure to show up to as many events as possible as well as enroll in any classes you may need to start your journey into the role of an EMT. After your 6 month probation, your membership will be voted on by the members.

We at the Hawthorne Volunteer Ambulance Corps look forward to working with you and helping you train for your own personal success as well as the success of the community in which you will serve. Thanks again for taking the time out of your life to help those in need.

Regards,

The Officer's Committee



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**Certified EMT**    **Auxiliary Member**    **Observer/Student**

**Personal Information**

Name: _____		Nick Name: _____	
Street Address: _____			
City: _____		State: _____	Zip: _____
Home Phone: _____		Email: _____	
Cell Phone: _____		<input type="checkbox"/> Verizon	<input type="checkbox"/> AT&T
		<input type="checkbox"/> T-Mobile	<input type="checkbox"/> Sprint
		<input type="checkbox"/> Nextel	<input type="checkbox"/> Other: _____
Date of Birth: _____		Social Security Number: _____	

### **Emergency Contact**

Name: _____		Relationship: _____	
Street Address: _____			
City: _____		State: _____	Zip: _____
Home Phone: _____		Cell Phone: _____	

### **Skills / Experience**

<input type="checkbox"/> First Aid / EMS	<input type="checkbox"/> Grants	<input type="checkbox"/> Fire Fighter	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> ICS	<input type="checkbox"/> WMD	<input type="checkbox"/> HAZMAT	<input type="checkbox"/> HAZCOM
<input type="checkbox"/> Medical Terms	<input type="checkbox"/> Nursing	<input type="checkbox"/> MICU	<input type="checkbox"/> Transport
<input type="checkbox"/> Fundraising	<input type="checkbox"/> MS Office	<input type="checkbox"/> Typing	<input type="checkbox"/> PC Repair
<input type="checkbox"/> Leadership	<input type="checkbox"/> Goal Oriented	<input type="checkbox"/> Detailed Oriented	<input type="checkbox"/> Web Design

**Please list any additional skills you have along with the areas you are interested in helping our organization with:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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### Work / Volunteer History

(List most current first)

**Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

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

**Work Phone:** \_\_\_\_\_ **May we contact this employer?**  Yes  No

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**Why did you leave this employer?**  N/A \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

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

**Work Phone:** \_\_\_\_\_ **May we contact this employer?**  Yes  No

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**Why did you leave this employer?**  N/A \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

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

**Work Phone:** \_\_\_\_\_ **May we contact this employer?**  Yes  No

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**Why did you leave this employer?**  N/A \_\_\_\_\_



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### Certification / Licenses

(Please provide copies)

**\*\*Not Applicable for Auxiliary Membership\*\***

<b>Driver's License:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	Identification Number: _____	
	Date Issued: _____	Expiration Date: _____	
<b>EMT:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	Identification Number: _____	
	Date Issued: _____	Expiration Date: _____	
<b>CPR:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	Identification Number: _____	
	Date Issued: _____	Expiration Date: _____	
_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Identification Number: _____	
<b>Other</b>		Date Issued: _____	Expiration Date: _____
_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Identification Number: _____	
<b>Other</b>		Date Issued: _____	Expiration Date: _____

### Background Information

**\*\*Not Applicable for Auxiliary Membership\*\***

<b>Type of driving experience:</b> <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Box Truck <input type="checkbox"/> Van Ambulance <input type="checkbox"/> Box Ambulance	
<input type="checkbox"/> Other: _____	
<b>Have any of your certifications or licenses been revoked?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Explain below)	
_____	
<b>Have you ever been arrested and convicted of a crime?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Explain below)	
<input type="checkbox"/> Reckless Driving	Date(s): _____
<input type="checkbox"/> Speeding	Date(s): _____
<input type="checkbox"/> Morals Offense	Date(s): _____
<input type="checkbox"/> Narcotics Offense	Date(s): _____
<input type="checkbox"/> DUI	Date(s): _____
_____	
_____	



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### Availability

**\*\*Not Applicable for Auxiliary Membership\*\***

<b>Times available for Training / Duty:</b>			
Sunday	Yes	No	Hours: _____
Monday	Yes	No	Hours: _____
Tuesday	Yes	No	Hours: _____
Wednesday	Yes	No	Hours: _____
Thursday	Yes	No	Hours: _____
Friday	Yes	No	Hours: _____
Saturday	Yes	No	Hours: _____
<b>Please list any restrictions that may or will affect your availability for volunteer work:</b>			
_____			
_____			

**I fully understand that the acceptance of this application is in no way binding upon the Hawthorne Volunteer Ambulance Corps.**

**I certify that the statements made herein are the truth, as it is known to me, and I do authorize the Hawthorne Volunteer Ambulance Corps or its agents or designee's to conduct such investigations as deemed necessary.**

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

ADMINISTRATIVE USE ONLY			
Date Application Received: _____	Date of Interview: _____		
Date Background Check Reviewed: _____	Date Credentials Reviewed: _____		
Date of Acceptance: _____	Comments: _____		
Officers Present During Interview: _____			
Corps Number Issued: _____	Membership Type: _____	Membership Status: _____	
Duty Crew Assigned: _____	Start Time: _____	Duration: _____	
Entered By: _____			



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## Parental Consent Form for Applicants who are Minors

To be completed by the parents or guardians of all applicants who are under 18 years of age

I / We hereby grant permission for our son / daughter to participate in the Hawthorne Volunteer Ambulance Corps. Permission includes but is not limited to participation in all duties, functions and activities required by the youth squad membership classification.

I / We have read the youth squad requirements outlined by the By-Laws of the Hawthorne Volunteer Ambulance Corps and hereby accept them in their entirety.

\_\_\_\_\_  
(Print Name of Applicant)

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name of Parent or Guardian signing above)

\_\_\_\_\_  
(Signature of Second Parent or Guardian) Optional

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name of Parent or Guardian signing above)



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#### DISCLOSURE AND CONSENT CONCERNING CONSUMER AND INVESTIGATIVE CONSUMER REPORTS

This form, which you should read carefully, has been provided to you because **Hawthorne Volunteer Ambulance Corps** ("Company") may request Consumer Reports and/or Investigative Consumer Reports from a consumer reporting agency. The Company will use any such report(s) solely for employment-related purposes. Consumer Reports or Investigative Consumer Reports will be obtained from CSS Inc. ("CSS") located at 20 E. Clementon Rd, Suite 201-S, Gibbsboro NJ, 08026. They can be contacted at 856-627-5600. Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., the Americans with Disabilities Act, the Drivers Privacy Protection Act and all other applicable federal, state, and local laws, I hereby authorize and permit CSS, to obtain a consumer report and/or an investigative consumer report which may include the following: Reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: credit reports, social security number, criminal records checks, public court records checks, including civil, driving records, educational records, verification of employment positions held, workers compensation records, personal and professional references, licensing, certification, etc. The information contained in these reports may be obtained by CSS from private or public record sources including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances.

**Additional State Law Notices:** Please see the next page to read the additional notices that may be relevant to you if you live in or are applying for work in any of the following states: **California, Maine, New York, Washington, Massachusetts, Minnesota, Vermont, Oklahoma, Connecticut, Oregon, or New Jersey.**

#### CONSENT

I have carefully read and understand this Disclosure and Consent form and, by my signature below, consent to the release of consumer and/or investigative consumer reports, as defined above, to the Company in conjunction with my application for employment. I further understand that any and all information contained in my job application or otherwise disclosed to the Company by me before, during or after my employment, if any, may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by the Company. I understand that if the Company hires me, it may request a consumer report and/or an investigative consumer report about me, as defined above, for employment-related purposes during the course of my employment. I understand that my consent will apply throughout my employment, to the extent permitted by law, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Company.

\_\_\_\_\_ I acknowledge that I have received the attached State Law Notices. (Please initial)

\_\_\_\_\_ I acknowledge that I have received the attached Summary of Rights under the Fair Credit Reporting Act. (Please initial)

Further, I acknowledge receipt of the attached summary of my rights under the Fair Credit Reporting Act and, as required by law, any related state summary of rights.

Applicant Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth (for ID purposes only): \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

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

City/State/Zip \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

#### **California, Maine, Massachusetts, Minnesota, New Jersey & Oklahoma Applicants Only:**

I wish to receive a free copy of any Consumer Report and/or Investigative Consumer Report on me that is requested.



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#### ADDITIONAL STATE LAW NOTICES

**California, Maine, Massachusetts, Minnesota, New Jersey & Oklahoma Applicants Only:** I have the right to request a copy of any Report obtained by COMPANY from CSS by checking the box below the signature line above.

**California, Connecticut, Maryland, Oregon and Washington State Applicants Only (AS APPLICABLE):** I further understand that COMPANY will not obtain information about my credit history, credit worthiness, credit standing, or credit capacity unless: (i) the information is required by law; (ii) I am seeking employment with a financial institution (California and Connecticut only – in California the financial institution must be subject to Sections 6801-6809 of the U.S. Code); (iii) I am seeking employment with a financial institution that accepts deposits that are insured by a federal agency, or an affiliate or subsidiary of the financial institution or a credit union share guaranty corporation that is approved by the Maryland Commissioner of Financial Regulation or an entity or an affiliate of the entity that is registered as an investment advisor with the United States Securities and Exchange Commission (Maryland only); (iv) the information is substantially job related, and the bona fide reasons for using the information are disclosed to me in writing, (Connecticut, Maryland, Oregon and Washington only);(v) I am seeking employment as a covered police, officer , peace officer or other law enforcement position (California and Oregon only - in Oregon the police or peace officer position must be sought with a federally insured bank or credit union ) , (vi) the COMPANY reasonably believes I have engaged in specific activity that constitutes a violation of law related to my employment (Connecticut only), (vii) I am seeking a position with the state Department of Justice (California only), (viii) I am seeking a position as an exempt managerial employee (California only), or (viii)) I am seeking employment in a position that involves regular access to personal information of others (i.e., bank or credit card account information, social security numbers, dates of birth), other than regular solicitation of credit card applications at a retail establishment, I am seeking employment in a position that requires me to be a named signatory on the employer's bank or credit card or otherwise authorized to enter into financial contracts on behalf of the employer, I am seeking employment in a position that involves access to confidential or proprietary information of the Company or regular access to \$10,000 or more in cash (California only).

**New York Applicants Only:** I also acknowledge that I have received the attached copy of Article 23A of New York's Correction Law. I further understand that I may request a copy of any investigative consumer report by contacting CSS. I further understand that I will be advised if any further checks are requested and provided the name and address of the consumer reporting agency.

**California Applicants and Residents:** If I am applying for employment in California or reside in California, I understand I have the right to visually inspect the files concerning me maintained by an investigative consumer reporting agency during normal business hours and upon reasonable notice. The inspection can be done in person, and, if I appear in person and furnish proper identification; I am entitled to a copy of the file for a fee not to exceed the actual costs of duplication. I am entitled to be accompanied by one person of my choosing, who shall furnish reasonable identification. The inspection can also be done via certified mail if I make a written request, with proper identification, for copies to be sent to a specified addressee. I can also request a summary of the information to be provided by telephone if I make a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or directly charged to me. I further understand that the investigative consumer reporting agency shall provide trained personnel to explain to me any of the information furnished to me; I shall receive from the investigative consumer reporting agency a written explanation of any coded information contained in files maintained on me. "Proper identification" as used in this paragraph means information generally deemed sufficient to identify a person, including documents such as a valid driver's license, social security account number, military identification card and credit cards. I understand that I can access the following website – [www.csscheck360.com](http://www.csscheck360.com) to learn more about CSS and view their current privacy policy at <http://www.csscheck360.com/privacy.pdf>.





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### Medical Release Form

\_\_\_\_\_ has made application to the Hawthorne Volunteer Ambulance Corps to become a Corp member. This involves first aid training, performance, driving of an emergency vehicle, stressful situations, lifting of patients, stretchers and equipment. We ask that you supply current medical information as well as some past medical history concerning the above named applicant. This will assist us in determining if the applicant would be able to successfully perform all the duties of a Corps member.

### History

1. Previous Hospitalization and Operations:

Date(s): \_\_\_\_\_

Where: \_\_\_\_\_

Reason(s): \_\_\_\_\_

\_\_\_\_\_

Family History: (Heart Disease, Hypertension, Diabetic)

\_\_\_\_\_

\_\_\_\_\_

2. Disabilities: \_\_\_\_\_

\_\_\_\_\_

3. Physical Impairments / Limitations: \_\_\_\_\_

\_\_\_\_\_

4. Allergies: \_\_\_\_\_

5. Medications: \_\_\_\_\_

### Physical Exam

1. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_ Pulse: \_\_\_\_\_

2. EKG:                      Normal                      Abnormal                      Date: \_\_\_\_\_

3. Spinal Exam:              Normal                      Abnormal Range of Motion: \_\_\_\_\_

4. Motion Sickness:    Yes                                      No



# Hawthorne Volunteer Ambulance Corps Membership Application Continued



5. Abnormal Test Results: \_\_\_\_\_

\_\_\_\_\_

6. Other: \_\_\_\_\_

\_\_\_\_\_

7. Last Physical Exam: Date: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_

8. Recommendations: \_\_\_\_\_

\_\_\_\_\_

9. Immunizations (Tetanus, Hep B): \_\_\_\_\_

*Do you feel that this applicant can physically and mentally perform as an Ambulance Corps*

**Member?**

Yes

No

Physician's Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### Volunteer Statement of Commitment

As a member of the Hawthorne Volunteer Ambulance Corps, I hereby make a commitment to:

1. Give \_\_\_\_\_ numbers of duty hours per month **≈70 hrs/month**
  1. One (1) Twelve (12) hour duty shift a week, each month **≈54 hrs/month**
  2. One (1) six (6) hour weekend duty shift a month **6 hrs/month**
  3. One (1) twelve (12) hour Saturday night duty shift every six (6) weeks **≈10 hrs/month**
2. Attend membership meetings as scheduled
3. Attend training sessions as scheduled
4. Attend Special Events as scheduled, such as Parades and Non-Emergent Stand-Bys
5. Attend Fundraising Activities as scheduled

As a member, I understand that I am a part of the staff of Hawthorne Volunteer Ambulance Corps and therefore, I can be asked to resign from membership. Causes for dismissal from the volunteer staff include, but are not limited to:

1. Failure to comply with the bylaws of the organization
2. Failure to comply with the Corps' Standard Operating Procedures
3. Failure to complete the required training programs
4. Failure to work a minimum time per month over a period of three (3) months
5. Failure to attend in-service training programs over a period of three (3) months
6. Breach of confidentiality; including HIPAA violations
7. Unethical behavior
8. Unwillingness to follow the directions of the officers

**Members**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Members**

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

**Corps Num:** \_\_\_\_\_

**Officers**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Officers**

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

**Corps Num:** \_\_\_\_\_



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### HVAC's In-House Training Program

#### Notice to Participants

HVAC'S In-House Training Program and individual courses are designed to supplement the initial training received by every EMT. Course material has been compiled by the Training Officer in consultation with fellow line officers and industry peers. HVAC members are encouraged to make use of the material provided and contact those HVAC members who have been identified in course materials to discuss the content in any particular area.

The In-House Training Program and individual courses being offered should not be viewed as a replacement for any course of study offered by the State of New Jersey, Department of Health, Office of Emergency Medical Services. It is not designed to replace the New Jersey Administrative Code of Section 8:40A or any Certificates of Waiver issued by the State of New Jersey. It also does not take the place of recertification.

It remains the responsibility of each individual EMT to comply with all requirements of the State of New Jersey, Department of Health. This program is but one tool to be used by HVAC Members in enhancing the Members' skill and experience. As the course material has not been created by HVAC but rather compiled from other sources, HVAC is not responsible for the content of the material or its application in the field. HVAC also assumes no liability for any misuse or misunderstanding of the materials provided.

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

**Name:** \_\_\_\_\_ **Corps Num:** \_\_\_\_\_



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#### HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM

##### ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received, I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

##### DECLINATION:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk for acquiring Hepatitis B (HBV), a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

##### CHECK ONE:

- I ACCEPT Hepatitis B vaccine inoculation, this is a series of 3 vaccines, initial injection, 2<sup>nd</sup> injection a month later, and the 3<sup>rd</sup> and final injection is 6 months after the initial. Complete series must be completed.
- I DECLINE Hepatitis B vaccine inoculation. I understand that by declining this vaccination, I continue to be at risk for acquiring Hepatitis B (HBV), a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.
- I have ALREADY BEEN vaccinated.

\_\_\_\_\_  
Volunteer's Name (Print)

\_\_\_\_\_  
Volunteer's Signature

\_\_\_\_\_  
Date



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## CONFIDENTIALITY AGREEMENT

### Acknowledgement of Special Responsibilities as a Volunteer with HVAC

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects the privacy of an individual’s health information under certain circumstances and makes it confidential. HIPAA mandates that in most instances, health information must be kept confidential unless the person gives specific written authorization or unless compelled by court order or subpoena, or when certain other conditions are met for release of health information.

By virtue of your association with Hawthorne Volunteer Ambulance Corps, you may need to know and, therefore, may be informed of certain health information that is necessary to perform your assigned duties. This includes access to databases, electronic media and other media forms that contain Protected Health Information as defined by HIPAA.

By signing this form, you acknowledge that you will take all steps necessary to keep all health information confidential that you obtain or become aware of in connection with your duties and responsibilities. This includes information relating to a patient’s health care history, diagnoses, condition, testing, prescriptions, treatment, evaluation or any other procedures related to the health of an individual. In addition, you agree not to use or disclose this information to any person except those persons directly necessary to the performance of your duties and responsibilities. If you are not sure about whether or not any information is confidential, you agree to ask an Ambulance Corps Officer.

Failure to keep health information confidential may result in monetary liability, civil penalties (fines) and/or criminal penalties provided for by law, and shall subject you to discipline up to and including dismissal, for violation of the Confidentiality of Health Care Information Act.

**Additionally, what is discussed, seen, heard or done within this organization is of confidential matter and shall not be spoken of to anyone outside the organization without prior permission obtained by a member of the Officer’s Committee. Anyone found to be discussing confidential Ambulance Corps business outside of the organization shall be subject to disciplinary actions.**

**I have read the above information and agree to keep health information confidential.**

**ORIGINAL SIGNATURE OF VOLUNTEER:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**RECEIVED BY:** \_\_\_\_\_ **ON** \_\_\_\_\_

(name)

(date)