Harrington Park Volunteer Ambulance Corps, Inc.
15 Kline Street
Harrington Park, NJ 07640

Application for Membership

Name: ____
Address ____
City: ____ State: _______ Zip Code: __________
Date of Birth: _________________________

Phone Number _________________________ Cell Phone _____________________________

Email Address: ____
Previous Training/Experience (if any):____

Signed: ____ Date: _______________

Medical Examination

(To be signed by a physician)

I certify to the best of my knowledge that there are no medical conditions which would preclude the above-named applicant from membership in the Harrington Park Volunteer Ambulance Corps.

Physician's Name: ____
Physician's Phone: ____

Signature: _______________________________________ Date: ______________________

Membership Approvals

Approval by Captain: Date: ___________ Initials: __________

Presented and Approval by Membership: Date: ___________ Initials: __________

Entered into Probationary Membership: Date: ___________ Initials: __________

Entered into Active Membership: Date: ___________ Initials: __________
(Minimum 6 months after Approved by the Membership and upon reaching a training level)

Signature: ____ Date: ___________
Captain

Mail Application to: Captain, Harrington Park Volunteer Ambulance Corps, Inc.
15 Kline Street, Harrington Park, NJ 07640