

UEMU MEMBERSHIP APPLICATION

Complete application and mail or return to:



Union Emergency Medical Unit
 2493 Vauxhall Road
 PO BOX 1773
 Union NJ 07083
 (908) 687-3373

1	NAME	First	Middle	Last	
2	ADDRESS	Street Address, Apt No.			
		City	State	Zip Code	
3	PHONE	Home	Work	Cell	
		() - _____ Area Number Code	() - _____ Area Number Code	() - _____ Area Number Code	
4	DATE OF BIRTH	_____ / _____ / _____ Month Day Year		5	
		EMAIL ADDRESS			
6	EMPLOYER	Company	Position	Phone	
					() - _____ Area Number Code
		Street Address, Apt No.			
		City	State	Zip Code	
7	DRIVERS LICENSE	Number	State	Expires	
				_____ / _____ / _____ Month Day Year	
		Restrictions			
		Have your driving privileges ever been revoked? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Have your driving privileges ever been suspended? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes please explain with dates and disposition: _____					

8	Have you ever been convicted of a crime (felony or misdemeanor) other than a motor vehicle offense? Yes <input type="checkbox"/> No <input type="checkbox"/>				

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9	If yes please explain with dates and disposition: _____ _____ _____							
10	Do you have past EMS experience? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Where?							
11	CERTIFICATIONS	Please provide dates when obtained and photo copies of any cards you possess as proof. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">CPR</td> <td style="width: 33%;">EMT-B</td> <td style="width: 33%;">Other</td> </tr> <tr> <td>_____/_____/_____ Month / Day / Year</td> <td>_____/_____/_____ Month / Day / Year</td> <td>_____/_____/_____ Month / Day / Year</td> </tr> </table>	CPR	EMT-B	Other	_____/_____/_____ Month / Day / Year	_____/_____/_____ Month / Day / Year	_____/_____/_____ Month / Day / Year
CPR	EMT-B	Other						
_____/_____/_____ Month / Day / Year	_____/_____/_____ Month / Day / Year	_____/_____/_____ Month / Day / Year						
12	EMERGENCY CONTACT	IN CASE OF EMERGENCY PLEASE CONTACT Name _____ Address _____ Phone _____ Relationship _____						
13	I, the undersigned applicant, do solemnly swear or affirm that the above statements are true to my own knowledge. Any falsification may result in the declination of my application or my dismissal from membership, if accepted. I also understand that acceptance into the Union Emergency Medical Unit is contingent upon my successful completion of an approved Emergency Medical Technician training course within one (1) year of the acceptance date.							
	YOUR SIGNATURE ➔ _____	Date _____/_____/_____ Month / Day / Year						
14	FOR APPLICANTS BELOW THE AGE OF EIGHTEEN (18) YEARS OF AGE <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">School Name</td> <td colspan="2">School Address</td> </tr> <tr> <td>School Phone () - _____ Area Number Code</td> <td>City</td> <td>State Zip Code</td> </tr> </table>		School Name	School Address		School Phone () - _____ Area Number Code	City	State Zip Code
School Name	School Address							
School Phone () - _____ Area Number Code	City	State Zip Code						
	PARENT OR GUARDIAN SIGNATURE / RELATIONSHIP ➔ _____	Date _____/_____/_____ Month / Day / Year						
DO NOT WRITE BELOW THIS LINE(FOR UEMU USE ONLY)								
Reviewed By:	Badge No:	Disposition: Accepted <input type="checkbox"/> Denied <input type="checkbox"/>						
Comments:								