



**THE TOWNSHIP OF MIDDLETOWN**  
**Emergency Medical Services Department**

1 Kings Highway  
Middletown, NJ 07748  
(732) 615-2252



Floyd Goldstein  
Chief

James Kelly  
Deputy Chief

Paul Kennedy  
Assistant Chief

**APPLICATION FOR MEMBERSHIP**

Please mail your application along with the physician's report, signed by your medical doctor, to either the squad closest to your residence or the Squad of your choice.

Thank You!

\_\_\_\_\_ Middletown First Aid & Rescue Squad Monmouth Pkwy.  
& Cruse Pl., Middletown

Mailing Address: P.O. Box 128, Middletown, NJ 07748 732-787-0099

\_\_\_\_\_ Fairview First Aid & Rescue Squad Kanes Lane,  
Middletown

Mailing Address: 17 Kanes Lane, Middletown, NJ 07748 732-275-1633

\_\_\_\_\_ Port Monmouth First Aid Squad

Wilson Ave. & Pulsch St., Port Monmouth

Mailing Address: P.O. Box 113, Pt Monmouth, NJ 07758 732-787-9566

\_\_\_\_\_ Leonardo First Aid & Rescue Squad Viola Ave.,  
Leonardo

Mailing Address: P.O. Box 222, Leonardo, NJ 07737 732-291-8650

\_\_\_\_\_ Lincroft First Aid & Rescue Squad Hurleys Lane,  
Lincroft

Mailing Address: P.O. Box 282, Lincroft, NJ 07738 732-842-0640

**TOWNSHIP OF MIDDLETOWN EMERGENCY MEDICAL SERVICES DEPARTMENT**  
**1 Kings Highway**  
**Middletown, NJ 07748**

Dena Hansen  
President

Chris Lombardi  
Vice President

Charmain Hueston  
Secretary

Dear Applicant,

Thank you for your interest in joining the Township of Middletown Emergency Medical Services Department. As you know, we are a totally 100% all volunteer service. We are always in need of new members, so please fill out your application as soon as possible and return it to the squad you wish your application to be submitted to.

Membership responsibilities vary from squad to squad, but can easily be summed up as: Fund Raising, meetings, drills and most importantly answering the call for help.

If you are willing and have the time to learn life-saving skills and help others in need, than you are the future of the Middletown Emergency Medical Services Department. Join our team today. As soon as your application is received, someone will contact you for an interview.

Again, thank you for showing an interest in the Township of Middletown Emergency Medical Services. We look forward to working with you in the near future.

Sincerely,

*Dena Hansen*

Dena Hansen  
President  
Township of  
Middletown EMS  
Department

**TOWNSHIP OF MIDDLETOWN EMERGENCY MEDICAL SERVICES DEPARTMENT**  
**1 Kings Highway**  
**Middletown, NJ 07748**

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_ S.S.#: \_\_\_\_\_

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

Mailing Address: \_\_\_\_\_  
(if different than above)

Years at present Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Supervisors Name/Title \_\_\_\_\_

Drivers Lic. #: \_\_\_\_\_ Exp. Date: \_\_\_/\_\_\_/\_\_\_

State: \_\_\_\_\_

Current Certifications (check all that apply)

\_\_\_ EMT exp. \_\_\_/\_\_\_ \_\_\_ CPR exp. \_\_\_/\_\_\_ \_\_\_ Hazmat \_\_\_ Def. Driving

Other: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a crime other than a traffic violation,  
if so please state county, and when:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any conditions that would keep you from performing your  
duties? If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_

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I hereby authorize the Township of Middletown Emergency Medical Services Department to examine my background with Law Enforcement Officials. I understand that any findings in said check will be kept confidential and, if applicable, will result in the rejection of my application. I understand that I must obtain a physical from a bonafide physician stating that I am able to complete all requirements put upon me by the Township of Middletown Emergency Medical Services and that all information obtained be kept confidential.

If accepted as part of the Township of Middletown Emergency Medical Services Department for membership, I promise to abide by the Constitution and the By-Laws of the organization and perform my duties to the best of my ability.

I attest that all information above is true to be the best of my knowledge and that any misrepresentation of information may be grounds for my immediate dismissal from the organization.

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**-----FOR OFFICIAL USE ONLY-----**

Date interviewed: \_\_\_/\_\_\_/\_\_\_ Approved for membership: **Y OR N**

Comments: \_\_\_\_\_

\_\_\_\_\_

Date accepted: \_\_\_/\_\_\_/\_\_\_ Membership Status: \_\_\_/\_\_\_/\_\_\_ Badge #: \_\_\_\_\_

Date of Active Status: \_\_\_/\_\_\_/\_\_\_ Date of Life Status: \_\_\_/\_\_\_/\_\_\_

Date of Resignation: \_\_\_/\_\_\_/\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

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PHYSICIANS REPORT

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

\_\_\_\_\_  
Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse \_\_\_\_\_

Blood Type: \_\_\_\_\_ Religion: \_\_\_\_\_ Organ Donor: Y or N

Medications: \_\_\_\_\_

Medical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Is there anything that would limit or restrict your patient to any duties pertaining to EMS?

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact:

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

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

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

Relation: \_\_\_\_\_

The above named patient is cleared to participate/perform in the duties of your organization with the following restrictions:

\_\_\_\_\_

\_\_\_\_\_

Signature of M.D. \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_