Beresford Community Ambulance Service

Application for Membership

I, ___________________________________, would like to become a member of the Beresford Community Ambulance Service. I agree to respond to emergencies, training, meetings and events for the good of the department whenever possible.

Age: ________________ Date of Birth: _________________

Address: ____

City/State: ____

E-mail address: ____

Driver's License: ____________________________ State issued: ______ Expiration date: _____________

(Please provide copy of driver's license front and back)

Phone: Day____________________ Night ____________________Cell_________________________

Please indicate your cell carrier: _____________________ (Verizon, AT&T, Etc…)

When are you available? Days _____________ Nights _____________ Weekends________________

Are you capable of performing with or without reasonable accommodation, the activities involved as ambulance personnel? Yes: ________ No: _______

If no, a confidential review by Ambulance President will be conducted.

Have you ever been convicted of a crime? Yes:________ No:________

If yes, please describe:____

Have you ever been convicted of a felony? Yes: _______ No:________

If yes, please describe:____

If yes, a confidential review by Ambulance President will be conducted.

Medical Education:

Certified EMT: Yes: _____________ No: ____________ In Progress: ______________

If yes, EMT number: SD State: ______________ Expiration date: ___________

National: ______________ Expiration date: ___________

(Please provide copies of EMT card and copy of CPR card, front and back)

If in progress, date of completion: _________________

Registered Nurse: Yes: __________ No: _____________ In progress: _____________

RN number: ______________________________

(Please provide copy of certification and CPR card, front and back)

EVOC Certified: Yes: __________ No: ____________

(Please provide copy of EVOC certificate and CPR card, front and back)

AUTHORIZATION AND UNDERSTANDING:

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of my application is true and complete. I authorize you to verify any of the information concerning my background including, but not limited to, my employment, driving record, education, or criminal history, with the appropriate individuals, companies, institutions or agencies, and I authorize them to release such information as you require, including my prior disciplinary employment record, without any obligation to give me written notice of such disclosure. I agree that any false information in support of my application may result in rejection of my application or, if not discovered until a later date, may result in immediate dismissal from Beresford Community Ambulance Service. I have read and will follow the rules and regulations of the Constitution and By-laws set forth by this organization. I agree and understand if accepted, I will be on probation for 6 (six) months.

Signature: ____ Date: _____________________

Application read into the minutes of the ___________ meeting.

(Month)

Action ____ Date: _________________

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Mandatory Confidentiality Agreement and HIPAA

All patients have a right to privacy and all volunteers must respect this right and comply with the Beresford Ambulance, South Dakota State Law and the Federal Law which ensures this right.

- Any information that can identify a patient is considered "Protected Health Information" or PHI. Divulging this information either written or verbally is considered a HIPAA violation.
- As Ambulance Personnel, regardless of certification, we are privy to protected information. This information is necessary to perform our duties.
- Never discuss anything about a patient unless it is in the performance of your duties and only then, to the proper person and in a manner and location, which ensures that the conversation will not be overheard.
- Never discuss anything about a patient that would release the Protected Health Information to those not privy to such information, this includes: knowledge of 911/call details, treatments performed, refusal or transport details, and transfer of care.
- Unless the patient gives permission to release specific information, DO NOT TELL ANYONE. This includes but not limited to (yours or patients): family members, co-workers, neighbors, friends, church members, bystanders, etc…
- Key: Remember WHAT you are saying, WHERE you are saying it, and WHOM are you discussing it with. These three W's can determine whether or not you are being compliant with HIPPA and other Confidential Information.
- In the circumstances that debriefing after a specific call is necessary for those involved, discussion with others immediately involved in the call is strongly encouraged. If additional or outside debrief is felt to be beneficial, leadership shall be contacted. Discussion with other members of Beresford Ambulance Service IS permitted but must remain in a protected environment (the Fire Hall/Ambulance Shed or personal residence). Discussions shall NOT take place in public areas such as: churches, gas stations, restaurants, pool, parks, during public outings, etc…

I hereby agree that I will not discuss, reveal, copy or in any other manner disclose any HIPAA or Confidential information that I may see, hear or encounter while performing duties with Beresford Volunteer Ambulance Service. I understand failure to comply with any of the statements aforementioned in this document is my responsibility and not that of Beresford Ambulance Service. Failure to comply would mean legal action and/or immediate disciplinary action, which may include dismissal from the service.

Name (Print clearly): ____

Signature: ____________________________________ Date: ____________________

Application read into the minutes of the ___________ meeting.
(Month)

Action ____ Date: ________________