Humboldt Area Rescue Squad/EMS (H.A.R.S.)

Membership Application

Name: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____ Pager: _____

Date of Birth: _____ SS #: _____ DL #: _____

Employer: _____ Work Phone: _____

References: (other than family)

1. Name: _____ Phone:_____
2. Name: _____ Phone:_____
3. Name: _____ Phone:_____

Specialist Training or Certification:

1. _____ Exp. Date: _____
2. _____ Exp. Date: _____
3. _____ Exp. Date: _____
4. _____ Exp. Date: _____
5. _____ Exp. Date: _____

I am available for call:

Days Only: ____ Nights Only: ____ Both: ____ Other: (explain) _____

In order for us to best know how to place you in a role of service with the rescue squad, do you have any physical limitations or conditions? Yes _____ No _____

If yes, please explain further: _____

_____

_____

By signing below I authorize the Humboldt Area Rescue Squad (HARS) to obtain a background check on me. I understand that this check consists of checking with my references and employer to determine my character as well as doing a check of my driving record and a check for any prior felony convictions. This information will be used solely as a means of determining eligibility for membership. I will not hold responsible or liable HARS, its officers or membership committee, for any decisions made from obtaining this information. HARS does not discriminate on basis of ages, race, sex, religion or national origin.

Application Signature: _____

Official use only:

Approved: _____ Denied: _____ Signed: _____ Date: _____

(Officer's Signature & Title)

Humboldt Area Rescue Squad

P.O. Box 855
Humboldt, TN 38343
Phone: 731-414-8055
Email

Humboldt Area Rescue Squad/EMS
Workforce Confidentiality Agreement

Humboldt Area Rescue Squad/EMS protects the privacy of patients, families, and employees; including safeguarding confidential and/or proprietary information. Whether you read, see, or hear things about patients, families, or employees, it is private and confidential and cannot be shared except as necessary for patient care or as otherwise authorized.

We protect any information, verbal, written, computer, electronic, photographs, or videotape. Employees, consultants, students, and physicians need access to confidential information to perform their assigned duties. However, maintaining confidentiality is a required duty of every employee, agent, physician, consultant, and all others with access to information.

BY SIGNING THIS CONFIDENTIALITY AGREEMENT, I UNDERSTAND AND ACKNOWLEDGE THAT:

1. I am aware of Humboldt Area Rescue/EMS Privacy Policy and that I have the opportunity to review the Policy.

2. I have the responsibility to ask for clarity or voice any concerns regarding confidential information to prevent violation from occurring.

3. I understand it is my responsibility to:
   a. Comply with the Privacy Policy.
   b. Protect and respect the privacy of patients and their information.
   c. Not access data on patients for whom I do not have responsibility and/or for whom I do not have a "need to know."
   d. Keep information confidential and not disclose it to others, including employees, patients, and patient's family members unless properly authorized.
   e. Refrain from conversations about information protected by the Privacy Policy.
   f. Refer all requests and inquiries for confidential information to those who are responsible for release of information.

4. If I am given access to computer systems, I understand it is my responsibility to
   a. Understand that my computer access code (password, personal identification number) is the equivalent of my legal signature.
   b. Keep secret all computer identifiers, passwords, PIN numbers, and access codes issued to me.
   c. Sign off after each computer session to prevent unauthorized use of the application.

5. I understand that violation of these requirements may result in disciplinary action up to and including termination of my employment, affiliation, and/or contractual rights with Humboldt Area Rescue Squad/EMS as well as any penalties prescribed by law. I understand and agree that this obligation continues in effect after I am no longer an employee or affiliate. I further understand and agree that legal action to enforce this obligation may be taken against me.

Name: _____ Date: _____

Signature: _____

Humboldt Area Rescue Squad

P.O. Box 855
Humboldt, TN 38343
Phone: 731-414-8055
Email: hars@click1.net

Humboldt Area Rescue Squad
Membership Agreement

The Humboldt Area Rescue Squad is a fully volunteer staffed organization that operates on donations from Humboldt and the surrounding area. It is very important that the members of our organization understand that certain criteria have to be maintained to operate successfully. Below are a few of very important guidelines.

1. Safety is number one and no one should act in a manner that jeopardizes someone else's safety.

2. Must attend no less than one monthly meeting per quarter to remain active, I understand I must notify an officer if I have to be absent.

3. Even though gifts are welcome from area merchants or suppliers a gift should be cleared with officers before accepting.

4. Respect should be shown to each one who is a member here. Back biting, gossip, rumors etc., will not be tolerated. Treat others the way you want to be treated.

5. I understand that I am not to respond to a call that I have not been dispatched to. Your scanner is not Central Dispatch. If you respond on your own, you are on your own.

6. Do not perform any skills you are not certified to do.

7. Do not enter a scene by yourself.

8. Obey all traffic laws. If you get a ticket it will be your responsibility to pay it, NOT HARS.

9. No cell phone pictures allowed to be taken on scene due to Hippa Law.

10. We are a non-smoking facility.

Use common sense, we are dealing with families like ours, show compassion and respect to the people we serve.

I have read and understand the above guidelines.

Name: _____ Date: _____

Signature: _____

Humboldt Area Rescue Squad

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Humboldt, TN 38343
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Drug and/or Alcohol Testing Consent Form

Member Agreement and Consent to Random Drug and/or Alcohol Testing

I hereby agree, upon a request made under the random drug/alcohol testing policy of Humboldt Area Rescue Squad/EMS (the Company), to submit to a drug or alcohol test and to furnish a sample of my urine, breathe, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Company to disclose any documentation relating to such a test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly- authorized Company officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its company physician, and any testing laboratory the Company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if the Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its company physician, and the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of the policy and the procedures as explained in the paragraph above.

This policy and authorization has been explained to me in a language that I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL IN THE ACCIDENT OR INJURY EVENT, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

Name: _____ Date: _____

Signature: _____

Company Representative: _____ Date: _____

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

MEDICAL STATEMENT
For Emergency Medical Services Professional License

The Office of Emergency Medical Services is the state agency responsible for the licensing of emergency medical services personnel. The mission of the agency is to oversee the delivery of pre-hospital emergency care and to safeguard the public from inappropriate or incompetent medical care in the pre-hospital environment. When issuing a license, it is understood that the individual can meet the demands, duties, and responsibilities listed below and examiner performing the evaluation is a licensed physician, nurse practitioner or physician assistant.

GENERAL DUTY REQUIREMENTS:
The general environmental conditions in which emergency medical service personnel work includes a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push, or lift and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having times to lift, move, carry and balance while moving in excess of 125 pounds (250 pounds 2 person lift). Motor Coordination is dexterity to bandage, splint and move patients, including properly applying invasive airways and administering injections.

Driving in a safe manner, accurately discerning street names, map reading, and the ability to correctly distinguish house numbers or business locations are essential tasks. Use of the telephone or radio for transmitting and responding to physician's advice is also essential. The ability to concisely and accurately describe orally to health professionals the patient's condition is critical. The provider must also be able to accurately summarize all data in the form of a written report.

_____
TYPE / PRINT APPLICANTS NAME

HAS BEEN EXAMINED AND DEMONSTRATES SUFFICIENT HEALTH TO PERFORM THE ESSENTIAL FUNCTIONS IN THE PRE-HOSPITAL ENVIRONMENT AS DESCRIBED IN THE GENERAL DUTY REQUIREMENTS ABOVE INCLUDING VISUAL ACUITY, SPEECH, HEARING, AND THE USE OF EXTREMITIES.

_____	_____	_____
PRINT PROVIDER NAME	**PROVIDER'S LICENSE NUMBER**	**STATE**
_____	_____	
PROVIDER'S SIGNATURE	**DATE**	

AUTHORIZATION FOR RELEASE OF INFORMATION:
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE EXAMINER NECESSARY FOR QUALIFICATION TO MY EMPLOYER FOR DETERMINATION OF MY ELIGIBILITY BY THE DIVISION OF EMERGENCY MEDICAL SERVICES.

_____	_____	_____
SIGNATURE OF APPLICANT	**SOCIAL SECURITY NUMBER**	**DATE**

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
800.233.1957 or 717.741.0911
vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ **Other** _____

☐ **Other** _____

Last Name:	First Name:	MI:
Date of Birth:	Date of Membership:	Social Security Number: / /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class ☐ **Mark if additional beneficiaries are listed on a separate paper and attached.** **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to insured**	**Date of Birth**	**Percent (must equal 100%)**
BENEFICIARY DESIGNATION – Contingent Class **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to insured**	**Date of Birth**	**Percent (must equal 100%)**

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	Relationship of Insured	Percent
One Beneficiary of a class: Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

*Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

Humboldt Area Rescue Squad/EMS

New Member Information

First Name: _____ Last Name: _____

DOB: _____ Email address: _____

Address (Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Service Provider: _____

_____

Call Number: # _____ (Will be assigned by a HARS Officer)

- ☐ *Application*
- ☐ *Background check*
- ☐ *Driver's License*
- ☐ *CPR Card*
- ☐ *Medical Statement*
- ☐ *Drug Test Form*
- ☐ *Vanessa K Free Course*
- ☐ *Medical Release*
- ☐ *Non-First Responder Agreement*
- ☐ *Continuing Education*
- ☐ *VFIS Form*
- ☐ _____
- ☐ _____