



An Equal Opportunity Organization

# SUFFIELD VOLUNTEER AMBULANCE ASSOCIATION

## Application For Explorer Program

205 Bridge Street - P.O. Box 642  
Suffield, CT 06078  
860-668-3881 - Fax 860-668-3884

### Part 1: To be completed by all prospective explorers

*The Suffield Volunteer Ambulance Explorer Program is for individuals who are 14 years of age or older and in high school. Please print clearly!*

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email Address: \_\_\_\_\_

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

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

City, State & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other: \_\_\_\_\_

(Please circle preferred contact phone number)

Are you a high school student? Yes/No Grade: \_\_\_\_ Graduation Date: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you been a member of the SVAA before? Yes/No If yes, when? \_\_\_\_\_

Do you serve in any other volunteer agencies or organization? Yes/No If yes, please list:

\_\_\_\_\_

Please list three personal and/or business references that we may contact:

Name	Relationship	Phone

**Part 2: To be completed by all prospective explorers**

By my signature below I acknowledge that I give permission for a representative from the SVAA to contact the references listed as well as any EMS or related organization that I am or have been involved with, and authorize the SVAA to investigate any and all statements.. I also give permission for these organizations to share with the SVAA any information that is pertinent to my membership with the previous or current organization and agree to hold harmless both the reference organization and the SVAA in regards to any information obtained in this process. The SVAA agrees to only use this information in the process of determining the applicant’s ability to perform the functions of the position for which they are being considered.

By my signature below I acknowledge the information provided on this application is accurate and factual to the best of my knowledge.

Membership in the SVAA is “at will” and may be terminated by the member or the SVAA at any time.

Printed name: \_\_\_\_\_

Last Four SSN #: XXX-XX-\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

**Do not write below this section**

Date completed application received: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date contacted by mentoring coordinator: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_