

Registration Form Volunteer Emergency Medical Technician

A member of this plan must be a certified EMT affiliated with a state licensed ambulance service. A copy of the signed EMT certification must be included with the registration.

SSN: _____

Name (Please Print) _____

Address _____
(Mailing Address) (City) (State) (Zip Code)

Email Address _____

Gender: M _____ F _____ Age _____ Birth Date _____ Phone#: _____

Ambulance Service Affiliation _____ Agency # _____

Check one: New _____ Transfer _____

PREVIOUS CONTRIBUTION INFORMATION

Were contributions previously made to the Pension Plan? Yes _____ No _____

If yes, please complete. Previously volunteered with:

1) _____ Date from: _____ to: _____

2) _____ Date from: _____ to: _____

Were contributions: Withdrawn _____ Left on Deposit _____

Contributions made under the name(s) of : _____

Spouse's Name _____ SSN _____ DOB _____

List below all children less than 21 years of age:

Name _____ SSN _____ DOB _____ GENDER _____

Note: Proof of your age, that of your spouse, and of the children, will be required before benefits are paid.

I hereby apply for membership in the Volunteer EMT Pension Fund and I certify that all statements hereon are true and correct to the best of my knowledge and belief.

Signature of Applicant

Date

EMS Office Use Only
I certify this individual is a certified EMT, is an attendant with a licensed ambulance service, and is eligible for this pension plan.
Name: _____ Title: _____ Date: _____

For WRS Office Use Only

Entered: _____
Verified: _____