



175 Wahconah St., P.O. Box 752, Pittsfield, MA 01202  
(413)499-2527

### Personal Information

Name		
Address		
City	State	Zip
Home Telephone (    )		
Work/Cell Telephone (    )		
Email		
Social Security #		
Are you affiliated with an ambulance/FD? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, who? _____		
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, you may be unable to sit for the Massachusetts certification exam		

The applicant, in order to be eligible for the State certification must:

- Be able to read, understand and communicate in English
- Meet all requirements as set forth by the Massachusetts Office of Emergency Medical Services for testing eligibility
- Be 18 years of age
- Be free from addiction to alcohol or any drug
- Be able to lift and carry 125 pounds
- Be free from any physical or mental defect or disease which might impair his/her ability to provide emergency care within the scope of the EMTs training and responsibilities, or which might jeopardize the health of another member of the class

I have completed this application truthfully and without falsification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You must return this application with a \$100.00 deposit or full payment of \$755.00 to *County Ambulance*. Payment should be in the form of cash, money order or via credit card MasterCard/VISA, American Express or Discover Card. Send payment with application to Christine Wright, County Ambulance Training Facility at 175 Wahconah St., Pittsfield, MA 01201.

**Please Note: All tuition fees are non-refundable after the first night of class.**

**OVER →**

FINANCIAL AGREEMENT

I, \_\_\_\_\_, understand and agree that I am entering an EMT training program sponsored by County Ambulance, Inc. I agree to pay tuition of \$755.00 and realize that the submission of this application and non-refundable fees commits me financially to a position in the program. This is evidenced by my signature on this date. I accept total and full responsibility for payment for the program regardless of my status in the program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**IF PAYING BY CREDIT CARD COMPLETE THE FOLLOWING SECTION**

**CREDIT CARD PAYMENT FORM**

I hereby authorize County Ambulance to charge my credit card for EMT training services.

\$ \_\_\_\_\_

Deposit: A \$100.00 deposit is due with this application. The balance of \$655.00 is due on or BEFORE the first night of class.

**Credit Card Information:**

Print Name \_\_\_\_\_

*Enter as it appears on credit card*

Billing Address for CC \_\_\_\_\_

Billing City, State \_\_\_\_\_ Zip \_\_\_\_\_

Credit Card Type (circle one)    Mastercard    VISA    American Express    Discover Card

Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

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

Payment by Check: \$ \_\_\_\_\_ Check # \_\_\_\_\_

Please attach check.

**A \$100.00 DEPOSIT IS DUE WITH THIS APPLICATION.**