

Adult Membership Application Form

We're here
for you 



In order for St John Ambulance Australia (NT) Inc. to maintain safety to its members & community we require all members to maintain a valid National Police Check & Working with Children's Card.

Applicant Details	
Title:	Full Name:
Preferred Name:	Date of Birth: Gender:
Home Address:	Postcode:
Postal Address:	Postcode:
Email Address:	Contact Number:
Occupation:	
Unique Student Identifier(USI) Number:	
Have you previously volunteered or been employed by St John Ambulance? Please provide details:	
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No	
Driver's License:	State Issued: Expiry:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NT <input type="checkbox"/> ACT <input type="checkbox"/> NSW <input type="checkbox"/> VIC <input type="checkbox"/> QLD <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS
Covid Vaccination:	*Please supply certificate with this application.
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Working With Children Clearance	Working With Children Card Number: Expiry:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact Details:	
Full Name:	Contact Number: Relationship:
Qualifications	
Year Completed:	Qualification Code: Qualification Title:
Which area of Volunteering are you interested in?	
<input type="checkbox"/> Event Health Services <input type="checkbox"/> Community Education	<input type="checkbox"/> Community Response Team <input type="checkbox"/> Operational Support

Referee Details		
Title:	Full Name:	
Relationship:	Contact Number:	Email Address:
Title:	Full Name:	
Relationship:	Contact Number:	Email Address:

If you currently hold any of the below, please provide copies:	
<input type="checkbox"/> NT Working with Children Clearance	<input type="checkbox"/> HLTAID003 Provide First Aid
<input type="checkbox"/> National Police Clearance	<input type="checkbox"/> HLTAID006 Provide Advanced First Aid
<input type="checkbox"/> NT Driving Licence (C Class)	<input type="checkbox"/> HLTAID007 Provide Advanced Resuscitation
	<input type="checkbox"/> AHPRA Registration

<p>Please ensure you understand the below conditions and requirements:</p> <p>I, hereby acknowledge as a volunteer member with St John Ambulance Australia (NT) Inc. I shall:</p> <ul style="list-style-type: none"> • Abide by current St John Ambulance Australia (NT) Inc. Policies, Procedures, and Code of Conduct. • Continually maintain or update my skills and knowledge in First Aid, and Child Protection practices • Hold a valid Northern Territory Working with Children Clearance • Present a positive image of St John Ambulance Australia (NT) Inc. to the community • Undertake a National Police Clearance initially, then bi-annually • Complete a three (3) month probationary period • Notify St John Ambulance Australia (NT) Inc. immediately of the suspension of my National Police Clearance, Working with Children Clearance, Driving License or any breach of Policies, Procedures or Code of Conduct • Return all Personal Protective Equipment (PPE), Uniforms, and Identification Cards issued upon my resignation from St John Ambulance Australia (NT) Inc

<p>Declaration:</p> <p>I, hereby authorise St John Ambulance Australia (NT) Inc. to contact my nominated referees in regard to my application to become a volunteer, and declare that all the information I have supplied in this application is correct and understand that any false declarations made above will invalidate my application. I also give St John Ambulance Australia (NT) Inc. permission to obtain my photograph and use the image along with my name for all marketing purposes including on social media platforms.</p>

Full Name:	
Signature:	Date:

Office Use Only:	
Director/Delegate Approval	
This application for registration to become a St John Ambulance Australia (NT) Inc. Volunteer has been reviewed and assessed as: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved <input type="checkbox"/> Approved (on condition):	
Full Name:	
Date:	Signature:

Adult Membership Medical Questionnaire

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Private & Confidential

To the best of your ability answer the questions below in the space provided, by ticking YES or NO.

COVID-19		
1.	Have you travelled overseas in the last 14 days? If YES, please specify regions:	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Have you travelled interstate in the last 14 days? If YES, please specify where:	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Are you experiencing any symptoms of COVID-19? (fever, sore throat, dry cough)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you come into close contact with anyone in the last 14 day who has/or may have COVID-19? If YES, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO

General		
1.	Have you ever had an operation, procedure or surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Are you an insulin dependent diabetic?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Are you epileptic or ever had a seizure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you ever had OR do you currently have? (please tick relevant) <input type="checkbox"/> Neck Injury/Back Injury, <input type="checkbox"/> Broken a Bone(s), <input type="checkbox"/> Arm or Leg Injury, <input type="checkbox"/> RSI, <input type="checkbox"/> Sciatica, <input type="checkbox"/> Frequent/Persistent Backache, <input type="checkbox"/> Hernia, <input type="checkbox"/> Wrist Strain	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Have you ever had OR do you currently have? (please tick relevant) <input type="checkbox"/> Asthma/COPD, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Stroke, <input type="checkbox"/> Heart Attack, <input type="checkbox"/> Artery or Vein Problems, <input type="checkbox"/> High Blood Pressure, <input type="checkbox"/> Collapsed Lung (Pneumothorax), <input type="checkbox"/> Pacemaker, <input type="checkbox"/> Palpitations or Irregular heart beat	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you ever had: (please tick relevant) <input type="checkbox"/> Head injury/concussion, <input type="checkbox"/> Severe headaches/migraines, <input type="checkbox"/> Vertigo, <input type="checkbox"/> Another neurological disorder, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Have you ever had: <input type="checkbox"/> Arthritis, <input type="checkbox"/> Blood Disorder, <input type="checkbox"/> Hepatitis, <input type="checkbox"/> Cancer/Tumour, <input type="checkbox"/> Kidney Problems, <input type="checkbox"/> Hearing Loss, <input type="checkbox"/> Vision Issues (Besides Glasses), <input type="checkbox"/> Any other chronic illness, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Are you able to do the following: Climb(ladders, stairs), Squat frequently, Work in dusty areas, Bend & lift, Push, Pull & reach, Read instruments, Read basic print	<input type="checkbox"/> YES <input type="checkbox"/> NO
9.	Do you take any regular medications including inhalers and patches? If YES, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO

10.	Do you have any allergies? If YES, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	Do you have: <input type="checkbox"/> Mental Health, <input type="checkbox"/> Psychiatric Illness or PTSD	<input type="checkbox"/> YES <input type="checkbox"/> NO
12.	Have you ever had, or been told by a doctor that you have a sleep disorder, sleep apnoea, or narcolepsy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
13.	Have you ever received/ do you have a mental health diagnosis? If YES, please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
14.	Have you got a mental health well-being plan in place?	<input type="checkbox"/> YES <input type="checkbox"/> NO
15.	Are there any situations you fell apprehensive about attending? If so, please provide comments below.	<input type="checkbox"/> YES <input type="checkbox"/> NO
16.	Do you suffer/experience or have you suffered/experiences any of the following: <input type="checkbox"/> Angina, <input type="checkbox"/> Fainting, <input type="checkbox"/> Anxiety/panic attacks, <input type="checkbox"/> Psychological disorders, <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO
Comments:		

Member to complete	I, hereby declare that I am physically able to undertake my duties with St John Ambulance Australia (NT) Inc. including being able to push, pull, carry and perform Cardio Pulmonary Resuscitation (CPR) in a pre-hospital/unpredictable setting. I understand that my fitness for duty will be reviewed annually by an approved assessor from St John Ambulance Australia (NT) Inc.
	Name: _____
	Signature: _____
	Date: _____

Volunteer Office to Complete	Is the applicant <i>required to undertake further examination</i> ?
	<input type="checkbox"/> No
	<input type="checkbox"/> Yes, please identify what: <ul style="list-style-type: none"> <input type="checkbox"/> A medical examination <input type="checkbox"/> An eye sight examination
	<i>Please refer to WHS.</i>
Name: _____	
Signature: _____	
Date: _____	