

# VAA MEMBERSHIP APPLICATION

## AGENCY INFORMATION

Agency Name:

OEMS Agency License #:

Phone:

Fax:

Address:

City:

State:

ZIP Code:

Private    Municipal    *(Please circle)*

Career    Volunteer    Combination

BLS    ALS    First Response

## PRIMARY CONTACT INFORMATION

Name:

Phone:

E-mail:

Fax:

Address:

City:

State:

ZIP Code:

Position:

EMT Certification Level:

## SECONDARY CONTACT

Name:

Phone:

Email:

Fax:

Address:

City:

State:

ZIP Code:

Position:

EMT Certification Level:

## AGENCY / MEMBERSHIP INFORMATION

In this space, please provide any information about your agency that you wish our current membership to know as well as how you believe the Virginia Ambulance Association can benefit your agency.

## SIGNATURES

I attest that I have the authority to complete and submit this application on behalf of my agency. I understand that membership is voluntary and requires maintenance of the annual dues as set by the VAA Board of Directors.

Name of applicant:

Signature of applicant:

Date:

Please complete the above form and submit via mail to:

**Virginia Ambulance Association Attn: Treasurer 49 Log Homes Dr. Harrisonburg, VA 22801**