MEMBERSHIP APPLICATON & REGISTRATION FORM
EMS/FIRST RESPONDERS

Name of Entity: _____

Office Phone: _____

Physical Address: _____City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

CEO or Chief: _____

Email Address (please print) _____ Cell: _____

Dispatch Number _____ Emergency Contact # _____

Please list the contact information for your Medical Director. *DO NOT* list the address and phone numbers for your organization as contact info for your Medical Director.)

Medical Director:_____

Mail Address: _____

Phone: _____

Email: _____

Medical Directors Emergency Contact Number (24/7): _____

RAC Representative: _____

Email Address (please print) _____ Cell: _____

Office Phone: _____

1. Alternate Representative: _____

Email Address (please print) _____ Cell: _____

Office Phone: _____

2. Alternate Representative: _____

Email Address (please print) _____ Cell: _____

Office Phone: _____

EMS Provider License # (**attach copy**) _____# Of Units_____

Provider License Held: BLS _____ ALS Cap. _____ ALS _____ MICU Cap ._____ MICU _____

Type of service Volunteer_____ Paid_____ and are you a 911_____ or Transfer_____

911 Providers List Counties with MOU's: _____

Population of your service area: _____

Square Miles of your service area: _____

Type Of Service VOL._____ Paid_____ 911_____Transfer_____

Signature: _____ Date: _____

☐ By typing in name will substitute for signature

Return completed application to: executivedirector@texasjrac.org or fax to 325-659-7107 or mail to
Texas J RAC
P.O. Box 60125
San Angelo TX 76906