Associate Membership Application

Member Information Form

About You: Complete this section in its entirety. **Please PRINT clearly**

Agency Name: _____

Address: _____ **County:** _____

City: _____ **State:** _____ **Postal Code:** _____

Business Phone: ( ) _____ **Cell Phone:** ( ) _____

Email Address: _____

Web Address: _____

Director/Chief: _____ **FAX:** ( ) _____

Population Served: Check the appropriate box

Under 500	500 - 1,000	1,001 - 3k	3K - 5K	5K - 20K	20K +

Who is the Senator who serves your area? _____

Who are the House of Representative members in your area? _____

_____

Please indicate the number of volunteer and paid staff are on your roster: RESCUE SQUADS/FIRE DEPT Only

Type of Personnel	Full Time	Part Time/Vol		Full Time	Part Time/Vol
Emergency Medical Responder - EMR			Paramedic		
Emergency Medical Technician - EMT			EVOC Driver		
EMT-Intermediate/85			Firefighter		
Advanced EMT - AEMT			Specialized Rescue		
Other (specify)					

ARTICLE III - MEMBERSHIP Section

Membership Criteria.

Eligibility for membership shall be approved by a majority vote of the Board of Directors and shall not be denied for reason of race, color, religion, sex, age or national origin. Membership will be open to any organization or entity meeting the criteria established in Section 2 herein, and willing to abide by the by-laws of the Association.

Section 2 B. Associate Membership. Rescue squads and First Responder agencies which are staffed by full time, part time or volunteers. Associate Members cannot be eligible for Active Membership. Associate Members shall not having voting rights, shall not hold office or serve on the Board.

APPENDIX A: Dues Structure

Associate Membership: $ 50.00 per Agency ☐

Completed Application can be mailed to:

SD Ambulance Association
PO Box 543
Spearfish, SD 57783

Administration Use Only:

Date Paid: _____ ***Amt Paid:*** _____

Check #: