



Calvert Advanced Life Support, Inc.

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LOSAP Affiliation Form

If you do not wish to change your affiliation from your current home department select "New Member"

NEW MEMBER: ☐

TRANSFER MEMBER: ☐

I DECLINE LOSAP: ☐ *(Complete this form and sign at the bottom of the page)*

FULL NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

My Department affiliation is (Specify CALS, VFD Co., Employer, etc.):

SIGNATURE: _____

DATE: _____

IMPORTANT: A copy of your certification (CPR, EMT, CRT, EMT-P and/or FF) must be provided with this signed form to qualify for LOSAP through Calvert Advanced Life Support (CALS)

SIGN BELOW **ONLY** IF YOU ARE **DECLINING** LOSAP THROUGH CALS

I have been given information about the LOSAP program and I voluntarily choose **NOT** to participate in LOSAP through CALS at this time. I understand that I can rescind this decision in the future, if roll size allows. I further understand that I do rescind this decision, it is **NOT** retroactive.

My signature is below:

SIGNATURE: _____

DATE: _____