

Form 9-a3

First Responder Information Form

Name:		SSN:	
Division/Dept.:		Job Title:	

1. First Aid Certification

Expiration Date:

County/State of Issue:

2. Cardiopulmonary Resuscitation Certification

Certificate Number:

Expiration Date:

Agency Issuing Certificate:

3. Emergency Medical Technician Certification

Certification Number:

Certificate Date:

Expiration Date:

County/State of Issue:

As a volunteer First Responder, I understand that I may be exposed to blood or Bloodborne Pathogens during the course of providing immediate first aid assistance to others. I have received a copy of the Bloodborne Pathogen Exposure Control Program. I have had an opportunity to review the Exposure Control Program, and I am familiar with all provisions to reduce my risk of exposure to blood and Bloodborne Pathogens outlined in the Exposure Control Program.

I understand that my role as a First Responder is voluntary and that I will receive no monetary or other material compensation for my services as a First Responder. I understand that I may withdraw my consent to act as a designated First Responder at any time.

Signature:		Date:	
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