

Peer Application

**THOMAS JEFFERSON EMS COUNCIL, INC.  
CRITICAL INCIDENT STRESS MANAGEMENT TEAM  
MEMBERSHIP APPLICATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Pager or cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

*Optional information:*

*Date of birth: \_\_\_\_\_ Marital status: (circle one) Single Married Divorced Separated*

*Children: (circle one) Yes No Ages: \_\_\_\_\_*

*Education: (circle highest completed) High School: 9 10 11 12 Diploma? Yes No*

*College: # of years \_\_\_\_\_ Degree? Yes No*

**Employment Information** (required – list most recent job first)

Employer: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Job title: \_\_\_\_\_

Job Description: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Job Title: \_\_\_\_\_

Job Description: \_\_\_\_\_  
\_\_\_\_\_

Peer Application

**Emergency Services Relationships:**

Agency affiliation (if any): \_\_\_\_\_ Rescue \_\_\_\_\_ Fire \_\_\_\_\_ Police \_\_\_\_\_ Hospital  
\_\_\_\_\_ Hospice \_\_\_\_\_ Other: \_\_\_\_\_

Agency name: \_\_\_\_\_

Agency address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Level of training or certification: \_\_\_\_\_ Years of service: \_\_\_\_\_

Have you had CISM training in the past? Yes No

If yes, when did you receive your training? Date: \_\_\_\_\_ Instructor: \_\_\_\_\_

Have you participated in or been a member of another CISM team? Yes No

If yes, please indicate location(s): \_\_\_\_\_

How did you hear about this CISM team? \_\_\_\_\_

Why do you want to volunteer with the CISM team? \_\_\_\_\_

Would you be able to make scheduled team meetings? Yes No

In which of the following functions would you be willing to participate? (please circle)

Defusings                      Debriefings                      Both

Do you think you would be able to participate in defusings/debriefings involving pediatrics?

Yes    No

**References:** List 3 persons who could address your application with the CISM team

1. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

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Comments or concerns:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return this application to:** Thomas Jefferson CISM Team  
2205 Fontaine Ave. Suite 302  
Charlottesville, VA 22903  
Phone: (434) 295-6146  
Fax: (434) 295-2009

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**For Office Use Only:**

Date Application Received: \_\_\_\_\_ Executive Comm. Review: \_\_\_\_\_

Applicant Outcome: Approved Denied Date: \_\_\_\_\_

ID Card Issued? Yes No Date: \_\_\_\_\_

Team Manual Issued? Yes No Date: \_\_\_\_\_

