Town of Pembroke Park Police Department

3150 SW 52nd Avenue, Pembroke Park, Florida 33023
Telephone: 754-232-1613 / Fax: 954-985-2172 / www.tppfl.gov

RIDE ALONG PROGRAM APPLICATION

Name: _____
DOB: _____
Race: _____
Sex: _____
Driver License Number: _____
Driver License State: _____
Telephone Number: _____
E-Mail Address: _____
Home Address: _____

Date Requested to ride along: _____
Hours Requested to ride along: _____

Comments:
_____
_____

_____ _____
Applicant Signature Date

Rules and General Information:

1. Applicants must be a minimum of 18 years of age.
2. A minimum of 3 days advance notice prior to the requested ride-a-long date is required to allow for application processing and scheduling.
3. Applicants are required to sign a liability release and covenant not to sue agreement prior to the ride along.
4. Applicants must complete the CJIS Level 1 Security Awareness Training, prior to being scheduled for a ride along.
5. Applicants must read and sign for the participants responsibilities form.
6. The applicant must provide photo identification (i.e., driver's license or other acceptable ID).
7. Attire is business casual.

Police Department Use Only:

FCIC/NCIC Printout Attached: _____
Copy of Identification Attached: _____
Application received by and date: _____
Supervisory Approval (Name and date): _____
Rode with Officer/ID/Date: _____

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION
FOR RIDE ALONG PARTICIPANTS

I am voluntarily providing the information below in case of a medical emergency that occurs while I am serving the Town of Pembroke Park in a voluntary capacity. I hereby give my consent for:

1. The administration of any necessary treatment by a licensed physician or dentist; and,
2. The transfer to _____ (preferred hospital) or any hospital reasonably accessible.

The following information may be released to the attending medical personnel, hospital, or licensed physician.

Participant's name:_____

Address: _____

Allergies:_____

Present medications:_____

Date of last Tetanus shot: _____

Physical impairments:_____

Pre-existing medical conditions:_____

Prior surgery/dates:_____

_____

Physician's name and phone #:_____

_____ _____
Date Signature of Participant

STATE OF FLORIDA
COUNTY OF BROWARD

The foregoing information was sworn to and subscribed before me this ____ day of _____, 202___ by _____, who is personally known to me or has produced _____ as identification and did take an oath.

_____ _____
Notary Public, State of Florida My Commission Expires:
Commission No. _____