HOWARD FIRE COMPANY

PO Box 276 – 341 Walnut Street
Howard PA 16841
Phone 814-625-2741
howardfire@gmail.com
www.howardfire.com

APPLICATION FOR MEMBERSHIP

Date of Application__________________

Name:____
Last First MI

Street Address:__________________________Mailing Address__________________________

____
City State Zip Township County

Email__________________________Phone(____)_____-________Cell(____)_____-________

Cell Phone Provider______________________________________(for alerts and notifications)

TYPE OF MEMBERSHIP APPLYING FOR:

____Junior ____Active ___Supporting

Birthdate:______/______/______
M D Y

Drivers License #:________________________ Class:_____ Expiration Date:______________

Employer Name: _____________________________ Occupation:________________________

Address: ____________________________________ Phone:______________________________

_____________________________________ Employed Since ___________________

Fire/EMS Experience – List company name, city, officer name, title, phone # and years served:

List Fire Training (SCBA, Haz-Mat, EVOC, etc.) you have completed. Attach Certificate copies:

List EMS training (EMT, CPR, etc.) you have completed & expiration date. Attach copies:

Narrative:
Please describe why you wish to become a member of the Howard Fire Company:

References:
Please list three references including addresses and telephone numbers.
Note: Junior member applicants must include at least one letter of recommendation from a teacher.

1.____

2.____

3.____

Do you have any motor vehicle law convictions or suspensions or were you involved in a motor vehicle accident in the past ten (10) years?
Yes **No** If yes, please explain:
____
____
____

Have you ever been convicted of any criminal offense? **Yes** **No** If yes, please explain:
____
____
____

I will submit a completed Pennsylvania State Police Background Check available at http://www.portal.state.pa.us/portal/server.pt?open=512&objID=4451&&PageID=458621&level=2&css=L2&mode=2 (PA State Police Website) and a PA Child Abuse Background check.

If I am moving to the area from out of state, I will submit an FBI background check - application information available online at http://www.fbi.gov/about-us/cjis/background-checks/backgroundchk

As an active member of the Howard Fire Company, I promise to attend as many training sessions, fire and emergency calls whenever possible. I also agree to participate in all other activities of the Howard Fire Company and Emergency Medical Services as possible. To the best of my knowledge, the information provided in this application is complete and correct. I authorize the Howard Volunteer Fire Company to review my background by making police agency checks that are deemed necessary. I also authorize my employer to release any and all information from my employment records. I understand that all services I shall give are strictly voluntary and upon acceptance I agree to abide by the By-laws, standard operating procedures and policies and lawful orders set forth by the Howard Fire Company. I give my authorization for the Howard Volunteer Fire Company to keep this application strictly confidential and on file.

Signature of Applicant_____________________________________ Date________________

Signature of Fire Company President _________________________Date________________

Signature of Recording Secretary _____________________________Date________________

Date Probationary Period Ends: ____________________________

PERSONNEL COMMITTEE USE ONLY
APPLICATION FOR MEMBERSHIP

Applicant Name____

Application Received Date____

Personnel Committee Reviewed____

References:

1) Comments/Impression:____

   Date contacted:_____________________Contacted by:___________________________

2) Comments/Impression:____

   Date contacted:_____________________Contacted by:___________________________

3) Comments/Impression:____

   Date contacted:_____________________Contacted by:___________________________

Personal Interview:

Date:_____________ Personnel Committee present____________________________________

Comments/Impression:

We, the undersigned members of the Personnel Committee recommend_____Approval or ____Rejection of _________________________for membership in the Howard Fire Company.

Signatures: ___________________________ Date: ___________________

___________________________ Date: ___________________

___________________________ Date: ___________________

___________________________ Date: ___________________

___________________________ Date: ___________________

___________________________ Date: ___________________

Date brought before the Company: _________________________________

Volunteer Firemen's Insurance Services, Inc.

ANNUAL MEDICAL STATEMENT OF PERSONNEL

NOTE: This form is designed to provide the officer in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other active members. If any of the questions are answered "YES", be sure the answer is fully explained.

QUESTIONS:

NAME: ______

ADDRESS: ______

CITY & STATE ______ ZIP: ______

FULL TIME OCCUPATION: ______

NAME OF ORGANIZATION: ______

ARE YOU A: ☐ Certified Vehicle Driver* ☐ Driver Trainee

Social Security No. ______

What is your Valid State Operators Plate No. ______

1. Birth Date: Month ______ Day ______ Year ______

2. Eyesight:
   - a. Have you lost use of either eye? ______ R ______ L ...... a. ☐ Yes ☐ No
   - b. Is peripheral (side) vision restricted? ...... b. ☐ Yes ☐ No
   - c. Are you color blind? ...... c. ☐ Yes ☐ No
   - d. Do you have, or have you ever had, cataracts? ...... d. ☐ Yes ☐ No
   - e. Are actual deficiencies corrected by glasses or contact lenses? ...... e. ☐ Yes ☐ No
   - f. Date of last eye examination ...... f. ______

3. Hearing:
   - a. Do you have difficulty hearing normal conversation level? ...... a. ☐ Yes ☐ No
   - b. Do you use a hearing aid? ...... b. ☐ Yes ☐ No

4. Diabetes:
   - a. Have you ever been treated for diabetes? ...... a. ☐ Yes ☐ No
   - b. Describe current medication and dosage, if any, and method of administration under "remarks".
   - c. Date of latest blood sugar test: ...... c. ______

5. Heart:
   - a. Have you ever been treated for heart disease? ...... a. ☐ Yes ☐ No
   - b. Describe condition: ...... b. ______
   - c. Describe current medication and dosage, if any, under "remarks"
   - d. Do you have a pacemaker? ...... d. ☐ Yes ☐ No
   - e. Date of last treatment or check up: ...... e. ______

6. Epilepsy:
   - a. Have you ever been treated for epilepsy? ...... a. ☐ Yes ☐ No
   - b. If "Yes", when was your last seizure? ...... b. ______
   - c. Describe current medication and dosage, if any, under "remarks"

REMARKS:

NOTE: If any question is answered "YES", give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

QUESTIONS:

7. Blood Pressure:
   a. Have you ever been treated for high blood pressure? .... a. ☐ Yes ☐ No
   b. If "Yes", when were you treated? .... b. ______
   c. What was your last reading? .... c. ______
   d. Describe current medication and dosage, if any, under "remarks".

8. Limbs:
   a. Have you lost an arm or leg? .... a. ☐ Yes ☐ No
   b. Have you lost the use of an arm or a leg? .... b. ☐ Yes ☐ No
   c. Does vehicle have special controls? .... c. ☐ Yes ☐ No
   d. If "Yes" to any of the above, describe under "remarks".

9. Miscellaneous:
   a. Have you ever had, or been treated for, Convulsions? .... a. ☐ Yes ☐ No
   b. If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
   c. Have you ever had any Fainting Spells? .... c. ☐ Yes ☐ No
   d. If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
   e. Have you ever had, or been treated for, Loss of Equilibrium? .... e. ☐ Yes ☐ No
   f. If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
   g. Have you ever been treated for Alcohol or Drug Abuse? .... g. ☐ Yes ☐ No
   h. If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
   i. Have you ever been treated for Mental Illness? .... i. ☐ Yes ☐ No
   j. If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".

10. What is the date of your last physical examination? .... ______

11. Are there any restrictions posted on your vehicle operator's license? .... ☐ Yes ☐ No

12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle? .... ☐ Yes ☐ No

13. When and for what purpose, did you last consult a doctor?

______

______

14. FULL NAME, address and telephone number of your personal physician.

NAME: ______

ADDRESS: ______

CITY & STATE: ______ ZIP: ______

PHONE NO.: ______

REMARKS:

The answers to the above are complete, accurate and true to the best of my knowledge.

______ SIGNATURE OF PERSON NAMED ABOVE ______ DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

"I authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, or person that has any records or knowledge of me or my health, to give Volunteer Firemen's Insurance Services, Inc. any such information."
A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

______ SIGNATURE OF PERSON NAMED ABOVE ______ DATE