FOR DEPARTMENT USE ONLY

Accepted as a Probationary Member: _____

Date App. Received: _____ Inactive / Resign Date: _____ Accepted as an Association Member: _____

CEDARVILLE FIREMEN'S ASSOCIATION INC.
APPLICATION FOR MEMBERSHIP

THE CEDARVILLE FIREMEN'S ASSOCIATION INC. DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, AGE, SEX, OR NATIONAL ORIGIN

Please submit with your application a copy of your driver's license, proof of vehicle insurance, all certifications, licenses, fire or medical training, and current physical. Please print in ink. Incomplete applications will be rejected.

Date: _____

PERSONAL INFORMATION:

Name :(first, middle, last) _____ D.O.B. _____
Driver's License #: _____ State: _____ SSN: _____
Current Address: Permanent Address (if different): Mailing Address (if different):
_____ _____ _____
_____ _____ _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
E-mail Address: _____
\ _____
_____
_____
Marital Status: _____ Number of Dependents: _____ Spouse comments: _____
_____

EMERGENCY CONTACT INFORMATION:

#1 Name: _____ Relation: _____
Address: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

#2 Name: _____ Relation: _____
Address: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

EDUCATIONAL BACKGROUND

High School: _____ Year Graduated: _____
College: _____ Major: _____
(Circle one) FR SO JR SR Anticipated or Actual College Graduation Date: _____

MILITARY SERVICE RECORD

Are you currently serving or have you ever served in the Armed Forces? _____
If YES, what branch? _____
What are your duties in the service? Include special training and duty station: _____
_____
Dates of duty: _____to_____ Rank: _____ Type of discharge: _____

FIRE AND MEDICAL EXPERIENCE

Have you been, or are you currently the member of another fire department? _____ If YES, list the department name, address, and reason for leaving_____

_____

List any certifications, licenses, and training in the fire and medical field (with state certification number):

_____

Are there any other experiences or qualifications, in which you feel you would be able to contribute to the department? _____

_____

ADDITIONAL INFORMATION Initial those that apply to you

_____ Corrective lenses have been prescribed
_____ History of hearing and/or respiratory problems: If yes, please explain:_____

_____

_____ Inability to handle stress
_____ Allergies, please list: _____
_____ Physical impairments, please describe: _____
_____ Currently taking medications, please list: _____

WORK HISTORY

Present employer: _____ Supervisor: _____
Address: _____ Phone #: _____
Position you hold: _____

Former employer: _____ Supervisor: _____
Address: _____ Phone #: _____
Position you held: _____ Reason for leaving:_____
May we contact the employers listed? If not, indicate below which one(s) you do not wish us to contact:

_____

REFERENCES Fill out completely; please exclude relatives

Name	Occupation	Address	Phone #
1.			
2.			
3.			

STATEMENTS AND SIGNATURE

If appointed, do you have a reliable means of transportation to get to the firehouse? (circle one) YES NO
Do you have a driving record of any type? _____ If Yes, describe in full: _____

_____

Have you ever been convicted of a felony? _____ If Yes, describe in full: _____
Have you ever been convicted of a crime? _____ If Yes, describe in full: _____
Do you currently use or have a history of abusing alcohol or illegal substances: _____ If Yes, describe in full:_____

I HEREBY CERTIFY THAT THE FACTS SET FORTH IN THE ABOVE APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE CONSIDERED SUFFICIENT CAUSE FOR DISMISSAL. _____ Initial

I HAVE READ AND UNDERSTAND THE REQUIREMENTS TO BE AN ACTIVE MEMBER FOR THE CEDARVILLE FIREMEN'S ASSOCIATION. _____ Initial

Print Name: _____ Signature: _____Date:_____

Consent to Background and Reference Check

Applicant Name: _____

Permanent Address: _____

Social Security Number: _____

Driver's License Number: _____ State: _____

I, _____ hereby authorize Cedarville Firemen's Association (the "Association") of 19 South Street, Cedarville, Ohio 45314, and/or its agents to make investigation of my background, references, character, past employment, consumer reports, education, and criminal history record information which may be in any state or local files, including those maintained by both public and private organizations, and all public records, for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications for membership. A telephone facsimile (fax) or xerographic copy of this consent shall be considered as valid as the original consent.

I hereby consent to the Association's verification of all the information I have provided on my application form. I also agree to execute as a condition of membership or a condition of continued membership any additional written authorization necessary for the Association to obtain access to and copies of records pertaining to this information. I also hereby authorize the Association's access to any medical histories or records pertaining to me (and any other individuals who due to my membership may be covered by any Association medical or other insurance program). With regard to the foregoing disclosures, I hereby agree to release any person, company, or other entity from any and all causes of action that otherwise might arise from supplying the Association with information it may request pursuant to this release. I understand that any false answers or statements, or misrepresentations by omission, made by me on this application or any related document, will be sufficient for rejection of my application or for my immediate discharge should such falsifications or misrepresentations be discovered after I become a member of the Association.

Print Name: _____

Signature: _____ Date: _____

Cedarville Firemen's Association
HEALTH HISTORY & PHYSICAL

The Cedarville Firemen's Association wishes to ensure the health of its applicants. Firefighting and EMS are inherently dangerous activities and should only be performed by those willing and able to work in environments that are immediately dangerous to life and health.

Date of exam:

Name _____ Gender _____ Date of Birth ____/____/____ Height _____ Weight _____

Home address _____

Home phone _____ SS# _____

Part I: **Personal Health History To** be completed by the patient

Explain "Yes" answers below.

	Yes	NO
1. Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
Have you had any serious accidents?	☐	☐
Are you presently under the care of a physician?	☐	☐

List any medications you are currently taking:

_____

_____

_____

	Yes	NO
3. Have you ever passed out?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
5. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐

	Yes	NO
6. Have you ever become ill from exercising in the heat?	☐	
7. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐

List any allergies: DRUG, FOOD, INSECTS, ENVIRONMENT:

_____

_____

_____

	Yes	NO
8. Have you ever had eating disorders/weight problems?	☐	☐
9. Have you ever had TB or any other communicable disease or exposure?	☐	☐
Have you ever had a positive reading on a tine, PPD, or TB skin test?	☐	☐
10. Do you have arthritis/bone problems?		☐
Have you ever broken any bones?		☐
Have you ever injured your back?		☐
11. FEMALES: Do you have menstrual difficulties?	☐	☐
12. Do you currently abuse illegal substances?		☐
Do you have a history of substance abuse?	☐	☐
13. Have you ever had emotional/mental health problems?	☐	☐
14. Any immediate family history of diabetes, heart disease or high blood pressure?	☐	☐
15. Are there any other medical conditions or concerns?	☐	☐

If **YES**, to any questions, please explain here: _____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby grant permission for this form and any other pertinent information to be sent to the Cedarville Firemen's Association upon completion.

Signature_____**Date:**_____

_____

PART II: QUESTIONS: (to be completed by Physician or Practitioner)

	NORMAL	ABNORMAL FINDINGS	INITIALS
The applicant must be…			
Able to hear			
Able to Bend / Squat			
Able to Climb Stairs with a load			
Able to Climb Ladders with a load			
Able to grip			
Able to do 60 minutes of Continuous heavy labor			
Able to Crawl on Hands and knees			
Free of Respiratory Diseases / Illnesses			
Free of Claustrophobia			
Free of Cardiac Conditions			
Free of psychiatric conditions that would prevent the individual from dealing with stressful situations			
Free of any ailment that might impede full participation in Fire Dept. Activities			

PART III: Physical Examination: (to be completed by Physician or Practitioner)

Pulse _____ BP _____/_____ Vision: R 20/ _____ L 20/_____

Corrected: ☐ YES ☐ NO Pupils: Equal Unequal Respiration Rate: _____

NORMAL	ABNORMAL FINDINGS		INITIALS
MEDICAL			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL/NEUROLOGICAL			
Neck & Back			
Shoulder / Arm / Hand			
Hip / Leg / Ankle			
Foot			
Nervous System			

- o I find no reason to prevent this person from serving with CTVFD
- o I find that this person may be able to serve after completing _____
- o I find that this person may be unable to serve with CTVFD due to _____

_____

Signature of Physician: _____ Date: _____

Physician (print/type):_____