VOLENTE FIRE DEPARTMENT

15406 FM 2769, Volente TX 78641

Phone (512) 258-1114 Fax (512) 335-0657

www.vvfd.net

APPLICATION for **MEMBERSHIP** Volunteer ☐ or PAID ☐ Your interest in joining the fire department is appreciated. The public service nature of our operation requires that we carefully screen applicants. Your honest and careful completion of this application is required. Please print all information.

NAME ____ DATE ____________________
LAST , FIRST MIDDLE (AS ON DRIVERS LICENSE) OF SUBMISSION

ADDRESS ___________ __________________________ , ________________ , TX. ________
NUMBER STREET CITY ZIP

HOME PHONE ______________ WORK PHONE _______________ PAGER or CELL ______________

DATE OF BIRTH _________________ AGE _________ SOCIAL SECURITY NO. __________________

DRIVER LICENSE NO. __________________ STATE _____ CLASS _____ RESTRICTIONS ___________

E-mail address:____
Attach a copy of drivers license and a copy of current personal automobile liability insurance.

EMPLOYER ____

ADDRESS ____

YEARS WITH PRESENT EMPLOYER ______ OCCUPATION/POSITION ____________________________

SUPERVISOR _____________________________________ WORK PHONE: __________________

Please list previous employers, phone numbers and length of employment for the past 10 years, attach a separate sheet as needed:

____

____

MARITAL STATUS SINGLE [ ] MARRIED [ ] IF MARRIED, SPOUSE'S NAME _____________________

*EMERGENCY CONTACT _________________________________ PHONE __________________

ADDRESS ____ RELATIONSHIP ____________

*BENEFICIARY _______________________________________ PHONE __________________

ADDRESS ____ RELATIONSHIP ____________

EDUCATION LEVEL - HIGH SCHOOL DIPLOMA YES [ ] NO [ ] G.E.D. OR EQUIVALENT YES [ ] NO [ ]
You must be a high school graduate or have an equivalent education. Attach a copy of diploma or transcripts.

COLLEGE YES [ ] NO [ ] YEARS ATTENDED _____ DEGREE(S) ______________________________
You may be required to provide copies of diplomas or transcripts.

MILITARY SERVICE YES [ ] NO [ ] IF YES, HOW LONG _______ TYPE OF DISCHARGE ____________
Provide a copy of your discharge papers or DD Form 214.

FIRE FIGHTING EXPERIENCE - Explain ______________________________

YEARS _____ From ____________ To ____________ CERTIFICATIONS ______________________
Attach copies of all training records and certifications. (Applicant should keep original documents.)

EMS EXPERIENCE - Explain ______________________________

TX. DEPT. OF HEALTH CERTIFICATION (ECA, EMT, EMT-I, EMT-P) ___________ EXPIRES ________________
Attach copies of EMS certification. (Applicant should keep original documents.)

FIRE DEPT. NAME ______________________________

REASON FOR LEAVING ______________________________

FIRE DEPT. REFERENCE ______________________________ PHONE ____________________

LIST THREE PERSONAL REFERENCES (Local area if possible. Do not list relatives. Phone numbers must be current.)

NAME ______________________________ PHONE ____________________

ADDRESS ______________________________

NAME ______________________________ PHONE ____________________

ADDRESS ______________________________

NAME ______________________________ PHONE ____________________

ADDRESS ______________________________

HOW LONG HAVE YOU BEEN A RESIDENT OF THE STATE OF TEXAS? ______________________
If less than three years, list below all address(s) of residency out of the state of Texas for the past three years.

____

____

NOTE - If you have lived in the state of Texas for less than three years and were previously a driver in another state, you will be required to obtain your own driving record from that state to cover a total of the past three year period. Include the out of state record with this application.

*LIST TRAFFIC VIOLATIONS OR CHARGEABLE ACCIDENTS FOR THE PAST THREE YEARS or indicate NONE

____

*HAS YOUR DRIVERS LICENSE EVER BEEN REVOKED OR SUSPENDED? YES [ ] NO [ ]

*HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A FELONY? YES [ ] NO [ ]

*HAVE YOU BEEN CONVICTED OF A MISDEMEANOR IN THE PAST THREE YEARS? YES [ ] NO [ ]

*ARE YOU CURRENTLY ON PROBATION or PAROLE? YES [ ] NO [ ]

*ARE ANY CRIMINAL CHARGES AGAINST YOU PENDING? YES [ ] NO [ ]

If you answered “YES” to any of the above questions, please explain the circumstances below or on a separate sheet:

____

____

____

* Any changes to items marked with an asterisk must be reported to the department within 72 hours.

RELEASE OF PERSONAL INFORMATION

I do hereby authorize a review and full disclosure of all records concerning me to any duly authorized agent of the Volente Fire Department whether the said records are of a public, private or confidential in nature.

The intent of this authorization is to give my consent to full and complete disclosure of the records of educational institutions, financial or credit institutions (including records of loans), the records of commercial or retail credit agencies (including credit reports and or ratings and other financial statements and records wherever filed), medical records, polygraph records, employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me and the records and recollections of Attorneys at Law, or of other counsel, whether representing myself or another person in any case either criminal or civil, in which I presently have or have had interest. I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly (in whole or in part), upon this release authorization will be considered in determining my suitability for service by the Volente Fire Department. I do hereby release said person(s) who provide information about me, whether supplied by a government organization or individual, from any and all liability, which may be incurred as a result of furnishing such information.

A photocopy or fax copy of this release form will be valid as an original thereof, even though the said photocopy or fax does not contain an original writing of my signature.

____

Signature Print Name

____

Address City, State, Zip

____

Phone Number Date of Birth

____

Social Security Number Driver license Number

State of ___________; County of _____________________________

Before me, the undersigned Notary Public of the State of ______________, on this day personally appeared ____, (Check one) ___known to me; ___ proven to me on the oath of ______________________________; or ___ proved to me through ________________________________(description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that s/he executed the same for the purposes and consideration expressed and in capacity expressed therein.

SUBSCRIBED AND SWORN TO before the undersigned authority this _______day

of _____________________ 20_____ ,

____

Notary Public

A poor driving record and/or certain criminal histories could be cause for rejection of your application. If you become a member, periodic personal driving record and criminal history checks may be made by the department. You should also understand and agree that controlled substance (drug) testing may be required by the department as part of an accident investigation and/or on a periodic, unannounced basis. Refusal to participate in this testing or positive test results may result in your dismissal from the department.

YOUR DRIVING AND CRIMINAL RECORDS ARE CONFIDENTIAL. Only those people directly involved in the application and eligibility process will have access to this information.

MEMBERS MUST MAINTAIN PERSONAL AUTO LIABILITY INSURANCE; ATTACH PROOF OR COPY.

YOU MUST COMPLETE THE ATTACHED "MEDICAL STATEMENT AND QUESTIONNAIRE".

I CERTIFY that I have read and understand this application and that the information, statements and attachments I have provided with this application are true and correct to the best of my knowledge and authorize the verification of same. Any misrepresentation or deliberate omission of a fact in this application shall be grounds for rejection of my application or, if a member, grounds for expulsion from the department. a photo copy of this release will be considered as an original.
‘

APPLICANTS SIGNATURE ____

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

MEMBERSHIP APPLICATION CHECKED BY OFFICER [ ]

ASSOCIATE MEMBERSHIP APPLICATION CHECKED BY DEPARTMENT OFFICER [ ]

CHECKED REFERENCES [ ] PREVIOUS FIRE DEPT [ ] MEDICAL STATEMENT [ ]

CHECKED AND ATTACHED: DRIVING RECORD [ ] CRIMINAL RECORD [ ] LIABILITY INSURANCE PROOF [ ]

COPY OF DRIVERS LICENSE [ ] COPY OF H.S. DIPLOMA OR EQUIVALENT [ ]

RECOMMENDATION: APPROVAL [ ] DISAPPROVAL [ ]

CHECKED BY - SIGNATURE ____ DATE ________________

Attached: Medical Statement and Questionnaire

VOLENTE FIRE DEPARTMENT

15406 FM 2769, Volente TX 78641

Phone (512) 258-1114 Fax (512) 335-0657

MEDICAL STATEMENT AND QUESTIONNAIRE

NAME ____ DATE _________________

HOME PHONE _______________________________ WORK PHONE _________________________________

DATE OF BIRTH _____________________________ HEIGHT _______________ WEIGHT _______________

DOCTOR'S NAME ____ PHONE _______________

Please describe, in your own words, the general state of your physical health and mental well-being.

____

Fire fighting, rescue operations and EMS activities can be physically and emotionally stressful. Do you have any condition or disability that might prevent or restrict your activities? Yes [ ] No [ ]

If yes, explain. ____

CHECK EACH ITEM: EXPLAIN "YES" ANSWERS TO QUESTIONS MARKED WITH AN ASTERISK (∗) IF ADDITIONAL SPACE IS REQUIRED, USE THE BACK OF THIS PAGE AND REFER TO QUESTIONS BY LETTER REFERENCE.	YES	NO
A. Are you blind in either eye?		
B. Do you wear glasses or contact lenses? If yes, what is your uncorrected vision?		
C. Have you had a tetanus shot? If yes, provide date of last shot.		
D. Have you ever lived with anyone who had tuberculosis?		
E. Are you allergic to bee, wasp or ant stings?		
F. Have you ever attempted suicide?		
G. Have you ever bled excessively after injury or tooth extraction? *		
H. Are you taking any medication for a chronic condition? *		
I. Have you used any illegal drugs in the last year? *		
J. Have you ever been treated for a mental condition? *		
K. Have you ever been denied life or health insurance? *		
L. Have you ever been advised to have any medical procedure or surgery? *		
M. Do you have any sensitivity to dust, sunlight or chemicals? *		
N. Have you been hospitalized within the past year? *		
O. Have you been treated by a doctor or any practitioner within the last year? *		
P. Are you unable to perform some motions, lift heavy objects or assume some positions? *		
Q. Do you smoke? If yes, how much per day? *		
R. Have you ever coughed up blood? *		
S. Have you ever been exposed to or checked positive for HIV? *		
T. Have you ever been knocked out or lost consciousness? *		

MEDICAL STATEMENT AND QUESTIONNAIRE - CONTINUATION

PLEASE CHECK EACH ITEM AND EXPLAIN "YES" ANSWERS ON THE BACK OF THIS PAGE
If you do not know the answer or are unsure of YES or NO, mark the box under the "**?**"

HAVE YOU EVER HAD:	YES	NO	?	HAVE YOU EVER HAD:	YES	NO	?
1. swollen or painful joints				31. leg cramps			
2. rheumatic fever				32. frequent indigestion			
3. dizziness or fainting				33. gallstones			
4. eye trouble				34. jaundice or hepatitis			
5. ear, nose or throat trouble				35. stomach or intestinal trouble			
6. hearing loss				36. broken bones			
7. sever headache				37. tumor, cyst or growths			
8. chronic colds				38. scarlet fever			
9. blood, albumen or sugar in urine				39. nervous trouble of any sort			
10. sinuses				40. rupture or hernia			
11. emphysema or bronchitis				41. piles or rectal trouble			
12. skin disease				42. kidney stone			
13. thyroid trouble				43. communicable disease			
14. head injury				44. arthritis or bursitis			
15. high blood pressure				45. asthma			
16. low blood pressure				46. loss of finger or toe			
17. shortness of breath				47. chronic back pain			
18. pain or pressure in chest				48. foot or knee trouble			
19. chronic cough				49. neuritis or nerve inflammation			
20. heart trouble				50. paralysis			
21. tuberculosis				51. tooth or gum trouble			
22. recent gain or loss of weight				52. trick knee, elbow or shoulder			
23. adverse reaction to drugs or serum				53. loss of memory or amnesia			
24. frequent or painful urination				54. palpitations or pounding heart			
25. liver trouble				55. received Hep-B vaccine			
26. epilepsy or seizures				56. trouble sleeping			
27. diabetes				57. depression or anxiety			
28. unconsciousness or fainting				58. fear of heights			
29. cancer				59. claustrophobia			
30. motion sickness				60. other phobias			

You may be required to provide a doctors statement confirming your physical ability to function as a firefighter.

I CERTIFY that the medical information supplied by me on these two pages is true and correct to the best of my knowledge. I authorize officials of the Volente Volunteer Fire Department to contact my doctor to verify this information and I authorize my doctor to release information needed for verification.

SIGNATURE ____ DATE _________________