Swarthmore Fire & Protective Association

SENIOR MEMBER APPLICATION

SWARTHMORE FIRE & PROTECTIVE ASSOCIATION

APPLICATION FOR MEMBERSHIP: Volunteer Status

This form is to be completed by the Proposer and the Applicant and filed with the Secretary at a regular meeting of the Swarthmore Fire & Protective Association. The Swarthmore Fire & Protective Association does not discriminate on the basis of race, color, sex, religion, or national and ethnic origin.

GENERAL INFORMATION

APPLICANT'S FULL NAME:_____ SS #:_____

ADDRESS:_____

PHONE:_____ BIRTHDATE:_____ AGE:_____ SEX:_____ MARITAL STATUS:_____

CELL PHONE:_____ E-MAIL: _____

INTERESTS (check all that apply): FIREFIGHTING: _____ EMS: _____ ASSOCIATE: ____

PREVIOUS ADDRESS:_____
(home town, if student)

EMPLOYER:_____ BUSINESS PHONE:_____
(school, if student)

EMPLOYER ADDRESS:_____ OCCUPATION:_____
(include class year, if student)

YEARS WITH PRESENT EMPLOYER:_____ FORMAL EDUCATION:_____

FIRE SERVICE/ MILITARY EXPERIENCE:_____

ANY PAST CRIMINAL HISTORY? **Y N** If yes, are you willing to discuss this with the Membership Committee? **Y N**

REFERENCES

Please provide at least three professional, character or personal references. If you are presently a member (Volunteer or Paid) of another emergency service organization (including medical transport companies), a professional reference from a company officer or supervisor is required. References from relatives or family members will not be accepted.

Name: _____ Relationship/Association: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____ E-Mail:_____

Name: _____ Relationship/Association: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____ E-Mail:_____

Name: _____ Relationship/Association: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____ E-Mail:_____

APPLICATION FOR MEMBERSHIP – *Continued*

ACTIVITY COMITTMENT

Do you realize that the Swarthmore Fire & Protective Association is not a social club and that as a member you will be required to give freely of your time to meet attendance requirements for emergency calls, meetings, drills, and training? **Y N**

Do you realize that the Swarthmore Fire & Protective Association has minimum training & participation requirements which must be met annually in order to retain membership? **Y N**

CERTIFICATION AND SIGNATURES

By signing this application I agree to undergo the required physical examination by a medical doctor and give the Swarthmore Fire & Protective Association or its agent(s) permission to conduct a background check with my employer, school, police and/or any other law enforcement authorities.

I understand that I have given permission to Swarthmore Fire & Protective Association or its agent(s) to conduct reference checks with the references provided, past, present or future employers, co-workers, family, friends, or any other acquaintances that I may have been in contact with.

I certify that the facts contained in my application for membership are true and complete to the best of my knowledge and understand that falsification and/or omissions of any information on this application is grounds for dismissal.

APPLICANT'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
(required if applicant is under 18 years old; if applicant is still in school, working papers are also required)

PROPOSER ENDORSEMENT

The proposer, a member in good standing of the Swarthmore Fire & Protective Association, recommends the above individual for membership.

PROPOSER'S SIGNATURE: _____ DATE: _____
The above signed agrees to present and propose the applicant to the general membership and assist with their application process.

INTERNAL USE ONLY - DO NOT WRITE BELOW THIS LINE

Investigating Committee use only (IC member initial and date when completed):

_____ APPLICATION RECIEVED _____ DUES RECEIVED

_____ RECOMMEND BY INVESTIGATION COMMITTEE _____ MEDICAL RECEIVED

_____ ACCOUNTABILITY TAG FORM RECEIVED _____ PHOTO ID TAKEN

_____ EMS/FIRE SCHOOL CONTRACT _____ JUNIOR/CADET CONTRACT

_____ SCHOOL WORKING PAPERS RECEIVED _____ REFERENCE CHECK(s)

_____ PA STATE POLICE CRIMINAL RECORD CHECK _____ PA DHS CHILD ABUSE

_____ FBI CRIMINAL RECORD CHECK & FINGERPRINT – (Only if not a PA resident for at least 10 years)

REFERENCE CHECK(s) FINDINGS: _____

_____

Secretary use only:

DATE MEMBERSHIP APPROVED: PROBATIONARY: _____ CADET: _____ JUNIOR: _____ SENIOR: _____

DATE AND REASON FOR DISCONTINUANCE OF MEMBERSHIP: _____

_____

Tri-Boro Accountability Tag Information Form

Information will be printed and sealed inside of your accountability tag. Information will be utilized in case of an emergency for accurate medical care. This information will be evaluated annually in case of change in medical status.

Your Name: _____

Emergency Contact:

Name: _____ Relation: _____
Number: _____

Alternate contact if desired

Name: _____ Relation: _____
Number: _____

Family Medical Doctor:

Name: _____Number: _____

Allergies to Medications:

Place check mark if none_____

- _____
- _____
- _____
- _____

Medical History:

Place check mark if none_____

- _____
- _____
- _____
- _____

Meds:

Place check mark if none_____

- _____
- _____
- _____
- _____

Please make sure all information is correct and sign below

Signature: _____ **Date:** _____

SWARTHMORE FIRE & PROTECTIVE ASSOCIATION

PHYSICAL EXAMINATION RECORD

Medical History (To be completed by applicant or examinee)

NAME: _____ SEX: _____ DATE OF BIRTH: _____ AGE:_____
(last) (first) (middle)

ADDRESS: _____ HOME PHONE:_____

PERSONAL PHYSICIAN: _____
(name) (address) (phone)

MEDICAL HISTORY: Please list all medical conditions/problems that you are currently diagnosed with or have been diagnosed with in the past:

_____

_____

_____

MEDICATIONS: Please list all medications that you are currently taking:

_____

_____

ALLERGIES: Please list any medications you are allergic to as well as any dietary or environmental allergies:

_____

IMMUNIZATIONS:

PPD: Date placed _____ Date read_____ Results ___(pos) __(neg)

if Positive, results of Chest X-Ray_____, appropriate treatment received _____

***PPD must be placed with Physical unless documentation is provided of a PPD test within the last year.**

When was your last Tetanus Toxoid booster? (approximate date) _____

Have you received a pertussis booster? _____

Are you up-to-date on the following vaccines?

	Yes	No	
Hepatitis-B (series of three shots)	___	___	
Polio	___	___	
MMR	___	___	
Chickenpox	___	___	(please note if you had chickenpox rather than the vaccine)

FAMILY HISTORY: (Mother, Father, Brothers, Sisters): List any significant diseases and age at death if any are deceased.

_____

_____

If any of the following are checked "Yes," give details in space provided (Age, condition, etc.)

Yes	No	
___	___	Have you ever been a patient in a medical hospital or a mental health institution? If yes, explain below.
___	___	Have you ever filed a compensation claim or received benefits as a result of an industrial injury or disease? If yes, explain below.
___	___	Have you missed more than a total of ten days work during the past two years? If yes, explain below.
___	___	Has your work ever been restricted because of your health? If yes, explain below.
___	___	Do you have any physical or mental complaint at present? If yes, explain below.
___	___	Do you use alcoholic beverages? Occasionally ____. Daily ____. How much? _____
___	___	Do you smoke? If yes, for how long, and how much? _____

.

Use this space to add any additional information:

I have reviewed the foregoing statements. This information is true and correct to the best of my knowledge.

_____
Signature of Applicant/ Examinee

MEDICAL EXAMINATION

Each applicant must have an age-appropriate medical screening exam for the completion of this form.

PATIENT'S NAME: _____ DATE: _____
(last) (first) (middle)

Position applied for: _____ REASON FOR EXAMINATION: _____
(Pre-placement, Annual, etc.)

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ TEMPERATURE: _____ PULSE: _____

	HEARING			**VISION**		
	Normal	Abnormal		Uncorrected	Corrected	**Color Vision**
Right			Right			Normal
Left			Left			Abnormal

Area Examined	Check here	**Explanation** ("**Check**" if Normal "**X**" if Not Examined "**A**" if Abnormal, and Explain)
General Appearance		
Skin		
Lymph Nodes		
Pulses		
Head and Neck		
Eyes		
Ears		
Nose and Throat		
Mouth and Teeth		
Chest and Lungs		
Heart		
Abdomen		
Hernia		
Spine		
Extremities		
Neurological		
Other		

Relevant lab results:

Clinician's Summary, Remarks, Diagnosis, and Recommendations:

Based on my exam findings, I certify that this applicant is physically fit for the duties of an EMT or a Firefighter, which include carrying equipment and patients, wearing personal protective gear, fighting fires, and communicating adequately with others.*

_____
Examining Clinician

*may circle only EMT or only Firefighter if appropriate.

NORTH AMERICAN BENEFITS COMPANY

CERT. NO.

POLICY NUMBER 1769-000001

MUST BE ANSWERED FOR ALL PLANS.

MY LAST NAME | FIRST | INITIAL | SEX ☐ M ☐ F | DATE OF BIRTH MO. DAY YEAR

MY OCCUPATION: Volunteer Firefighter/EMS

NAME OF MY EMPLOYER: Swarthmore Fire & Protective Relief Assn.

AMOUNT OF EARNINGS $ 0 ☐ Hr. ☐ Wk. ☐ Mo. ☐ Yr.

FULL-TIME EMPLOYMENT DATE MO. DAY YEAR

SOCIAL SECURITY NO.

FILL IN WHEN GROUP POLICY PROVIDES DEPENDENT BENEFIT

Do you have eligible Dependents? ☐ Yes ☐ No

Check dependents you wish to insure

☐ Spouse ☐ Children ☐ None

Spouse's Signature _____

Dependent Age 18 Or Older Signature _____

SPOUSE'S DATE OF BIRTH MO. DAY YEAR

IF PLAN REQUIRES PAYROLL DEDUCTIONS COMPLETE THIS PORTION

CONTRIBUTORY LIFE ☐ Yes ☐ No INSURANCE AMOUNT $_____

WEEKLY INDEMNITY ☐ Yes ☐ No LONG TERM DISABILITY ☐ Yes ☐ No

IF PLAN PROVIDES LIFE, OR ACCIDENTAL DEATH INSURANCE, COMPLETE THIS PORTION

BENEFICIARY'S LAST NAME | FIRST | INITIAL | AGE | RELATIONSHIP TO EMPLOYEE

Primary _____

Contingent _____

Your benefits will be paid first to the Primary beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent beneficiary(ies). (Legal appointment of guardian is required if minor is named as beneficiary.)

PLEASE READ, DATE AND SIGN THIS PORTION

I am an active, full-time employee. The complete terms of the group insurance coverage will be set forth in the group insurance policy(ies). If my employer requires contributions for the insurance I have selected, I authorize my employer to deduct such contributions from my wages.

_____ Date Signed

_____ Signature of Employee

2658 SF-1

WHITE – NABCO YELLOW – Group Policyholder GREEN – Employee's Copy

Swarthmore Fire & Protective Relief Association

NOTE TO MEMBER-Our Volunteers are protected with Group Insurance. It is to your advantage to name a beneficiary. Please show the following information. Return to Secretary immediately. THIS IS IMPORTANT.

Member's Name: _____

Member's Date of Birth: _____

Beneficiary of death benefit. (Print full name, address, telephone number, and relationship of each to Proposed Insured.)

(a) Primary Class (will receive payment first, if living and not disqualified)

_____

(b) Contingent Class (will receive payment only if living, not disqualified, and if no primary beneficiary receives payment.)

_____

Member's Signature: _____ Today's Date: _____