Mill Hall Volunteer Fire Company

9 East Peale Avenue, Mill Hall, Pennsylvania 17751

Firehouse: 570-726-4792 Website: www.millhallfire.com

APPLICATION FOR MEMBERSHIP

Step 1 – Applicant General Information

- Must be a legal resident of the United States of America.
- Applicants 16 to 18 years old must apply for a Junior firefighter membership and a copy of their working papers must be attached to this application.
- A background check, drug test, and medical physical will be necessary for the approval of your application. The Fire Company will pay for the application process unless drug test is failed. (Junior Members already have their physical through their Working Papers.)
- Must live within fifteen driving miles of the MHVFC firehouse if applying for a Regular, Dual or Junior Membership.

(PLEASE PRINT CLEARLY)

Type of membership desired: ☐ Regular ☐ Dual ☐ Junior (Please check applicable memberships desired.)

Name: _____
Last *First* *Middle*

Address: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Emergency Contact Person: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Have you ever applied for membership to this fire company in the past? ☐ Yes ☐ No

Have you ever been a member of a fire company or EMS service before? ☐ Yes ☐ No

If you answered yes to the previous question, indicate what organizations you were or are a member:

Driver's License No.: _____ Issuing State: _____ CDL License: ☐ Yes or ☐ No

Have you ever had a loss of driving privileges in the past? ☐ Yes ☐ No If yes please explain:

Have you ever been convicted of DUI? ☐ Yes ☐ No If yes please explain:

Have you ever been convicted of a crime? ☐ Yes ☐ No If yes please explain:

Do you have an EVOC Certification to drive emergency vehicles? ☐ Yes ☐ No

Are you presently an EMT? ☐ Yes ☐ No If yes, what is your Certification No.: _____ .

Employer: _____ Occupation: _____

Employer's Address: _____

List 3 references: (No relatives or present fire company members.)

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

HEALTH QUESTIONS

If any question is answered "yes" please provide an explanation. Please identify the remark's explanation that it pertains to: e.g. "1.a.". Also include dates, symptoms, duration, treatment results, medications, names and address of doctors, hospitals, etc.

1. Eyesight:
   a. Have you ever lost use of either eye? ☐ Yes ☐ No If yes please explain below under "remarks."
   b. Is peripheral (side) vision restricted? ☐ Yes ☐ No
   c. Are you color blind? ☐ Yes ☐ No
   d. Do you or have you ever had cataracts? ☐ Yes ☐ No
   e. Are actual deficiencies corrected by glasses or contact lenses? ☐ Yes ☐ No
   f. Date of last eye examination: _____ .
2. Hearing:
   a. Do you have difficulty hearing normal conversations? ☐ Yes ☐ No
   b. Do you use a hearing aid? ☐ Yes ☐ No
3. Diabetes:
   a. Have you ever been tested for diabetes? ☐ Yes ☐ No
   b. Describe current medication and dosage, if any, and method of administration below under "remarks."
   c. Date of last blood sugar test: _____ .
4. Heart:
   a. Have you ever been treated for heart disease? ☐ Yes ☐ No
   b. If yes describe condition: _____ .
   c. Describe current medication and dosage, if any, below under "remarks."
   d. Do you have a pacemaker? ☐ Yes ☐ No
   e. Date of last treatment or checkup: _____ .
5. Epilepsy:
   a. Have you ever been treated for epilepsy? ☐ Yes ☐ No
   b. If "yes", when was your last seizure? _____ .
   c. Describe current medication and dosage, if any, below under "remarks."
6. Blood Pressure:
   a. Have you ever been treated for high blood pressure? ☐ Yes ☐ No
   b. If yes when were you treated? _____ .
   c. What was your last pressure reading? _____ .
   d. Describe current medication and dosage, if any, below under "remarks."

7. Limbs:
   a. Have you lost an arm or leg? ☐ Yes ☐ No If yes please explain below under “remarks.”
   b. Have you lost the use of an arm of leg? ☐ Yes ☐ No If yes please explain below under “remarks.”
   c. Does your vehicle have any special controls? ☐ Yes ☐ No If yes please explain below under “remarks.”
8. Miscellaneous:
   a. Have you ever been treated for convulsions? ☐ Yes ☐ No If yes please explain below under “remarks.”
   b. Have you ever been treated for loss of equilibrium? ☐ Yes ☐ No If yes please explain below under “remarks.”
   c. Have you ever had fainting spells? ☐ Yes ☐ No If yes please explain below under “remarks.”
   d. Have you ever been treated for alcohol or drug abuse? ☐ Yes ☐ No If yes please explain under “remarks.”
   e. Have you ever been treated for a reaction to a TB test? ☐ Yes ☐ No If yes please explain under “remarks.”
   f. Have you ever been treated for Hepatitis B? ☐ Yes ☐ No If yes please explain under “remarks.”
   g. Have you ever been treated for mental illness? ☐ Yes ☐ No If yes please explain below under “remarks.”
   h. Do you have any allergies? ☐ Yes ☐ No If yes please explain below under “remarks.”
   i. Do you have other illnesses / health issues not mentioned? ☐ Yes ☐ No If yes please explain under “remarks.”
9. What was the date of your last physical? _____ .
10. Are there any restrictions posted on your Driver’s License? ☐ Yes ☐ No If yes, please list: _____

    _____
11. 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 If yes please explain: _____

    _____
12. When and for what purpose did you last consult a physician? _____

    _____
13. Full name, address and telephone number of your personal physician:

    Name: _____
    Last *First* *Middle*

    Address: _____

    Office Phone: _____ E-Mail Address: _____

REMARKS: _____

CERTIFICATIONS

Please list any certifications that you may have that are related to the fire or EMS field as well as any expiration dates:

Certification	Issued	Expiry

Copies of all certifications must be provided.

BACKGROUND CHECK RELEASE INFORMATION AUTHORIZATION

"I affirm that the information I supplied is correct to the best of my knowledge. I authorize the Volunteer Fire Company of Mill Hall, PA 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 give my authorization for the Volunteer Fire Company of Mill Hall, PA to keep this application and contained information on file."

Applicant Signature: _____ Date: _____

Step 2 – Applicant Drug Screening

This drug screening will be necessary for the approval of your application completed by the Fire Company recommended health provider.

After the successful completion of the drug screening you now proceed to the applicant physical screening.

Step 3 – Applicant Physical Screening

This physical screening will be necessary for the approval of your application completed by the Fire Company recommended health provider.

After the successful completion of the physical screening you are now ready for recommendation as a Member of the Mill Hall Volunteer Fire Company.

MEDICAL INFORMATION RELEASE AUTHORIZATION

"I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give the Volunteer Fire Company of Mill Hall, PA any such information." (Official photocopies and/or e-mailed files will be acceptable.)

Applicant Signature: _____ Date: _____

APPLICANT MEDICAL PHYSICAL EXAM REPORT

Doctor's Record

Applicant's Name: _____
Last *First* *Middle*

Address: _____

Date of Birth: _____ Examination Date: _____

☐ Vision Check (Distance, Peripheral, Color): _____

☐ Hearing Test: _____

☐ Reflexes Check: _____

☐ Pulmonary Function: _____

☐ Urinalysis Test (Drugs & Diabetes): _____

Upon successful results of your drug screening you will move to the next level of the application process.

If the drug test is failed then you will not be reimbursed for the testing.
If you don't pass the drug screen in the physical

FIRE COMPANY USE ONLY

Three member committee appointed to investigate applicant:

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

(Application must be signed by a minimum of two of the above members prior to being presented at a regular meeting of the Volunteer Fire Company of Mill Hall, PA.)

Applicant _____ was (accepted / rejected) at a regular meeting of the Volunteer Fire Company of Mill Hall, PA to proceed with the doctor's physical and upon a good report will become a _____ member of the Volunteer Fire Company of Mill Hall, PA. If the doctor's physical is failed then the applicant is rejected until such time the doctor's physical can be passed satisfactorily.

Recording Secretary Signature: _____ Date: _____
Volunteer Fire Company of Mill Hall, PA