PIONEER FIRE COMPANY, NO. 1

Jenkintown Fire Department

700 Greenwood Avenue, Jenkintown, PA 19046

APPLICATION FOR MEMBERSHIP

NAME:_____

HOME ADDRESS: _____

_____

DATE OF BIRTH: _____SOCIAL SECURITY NUMBER: _____

LENGTH OF TIME AT ABOVE ADDRESS_____

IF LESS THAN 5 YEARS GIVE PREVIOUS ADDRESS:

_____

_____

CURRENT PLACE OF EMPLOYMENT:

_____

PHONE #_____ CONTACT: _____

OCCUPATION:_____

LENGTH OF TIME WITH ABOVE EMPLOYER:

_____

TELEPHONE NUMBERS:

HOME: _____ CELL: _____

DRIVERS' LICENSE NUMBER: _____

STATE: _____ RESTRICTIONS: _____

HAS YOUR LICENSE EVER BEEN SUSPENDED OR REVOKED FOR ANY

REASON? YES / NO (CIRCLE ONE). IF YES LIST DATE (S) AND REASONS:

_____

MILITARY SERVICE: YES NO BRANCH: _____

DATES FROM_____ TO _____

HONORABLE DISCHARGE YES NO MILITARY DISABILITY YES NO

REFERENCES – EXCLUDING RELATIVES:

1.) NAME:_____

ADDRESS: _____

PHONE # _____

2.) NAME:_____

ADDRESS: _____

PHONE # _____

DO YOU HAVE ANY PRIOR PUBLIC SERVICE EXPERIENCE? YES NO

IF SO – WHERE:_____

WHEN:_____

CAPACITY: _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO

BRIEF EXPLANATION: _____

_____

_____

DO YOU HAVE ANY PHYSICAL CONDITIONS THAT MAY IMPAIR YOUR PERFORMANCE AS A FIREFIGHTER OR FIRE POLICE OFFICER? YES NO

BRIEF EXPLANATION: _____

_____

SIGNING BELOW ALLOWS THE PIONEER FIRE COMPANY TO MAKE ANY PERTINENT INQUIRES RELATIVE TO YOUR CRIMINAL HISTORY

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ **DATE:** _____

APPLICANTS UNDER EIGHTEEN (18) YEARS OF AGE MUST HAVE WRITTEN PERMISSION FROM A PARENT OR GUARDIAN.

THE ABOVE NAMED APPLICANT, BEING UNDER EIGHTEEN (18) YEARS OF AGE, DOES HEREBY HAVE THE PERMISSION OF THE UNDERSIGNED PARENT OR GUARDIAN.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP: _____

- **********

DO NOT COMPLETE THIS SECTION – FOR FIRE COMPANY USE ONLY

TYPE OF MEMBERSHIP: _____

PROPOSED BY: _____

RECOMMENDED BY: 1.) _____

2.) _____

PROPOSED TO MEMBERSHIP: _____

VOTED ON BY MEMBERSHIP: _____

11/11/05

Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual 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 employees. 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: _____

Position/Title: _____

Social Security No. _____

What is your Valid State Operators Plate No. _____

1. Birth Date: Month: _____ Day: _____ Year: _____

		Yes	No
2. Eyesight:			
a. Have you lost use of either eye? _____ R _____ L	a.	☐	☐
b. Is peripheral (side) vision restricted?	b.	☐	☐
c. Are you color blind?	c.	☐	☐
d. Do you have, or have you ever had, cataracts?	d.	☐	☐
e. Are actual deficiencies corrected by glasses or contact lenses?	e.	☐	☐
f. Date of last eye examination:	f.	_____	
3. Hearing:			
a. Do you have difficulty hearing normal conversation level?	a.	☐	☐
b. Do you use a hearing aid?	b.	☐	☐
4. Diabetes:			
a. Have you ever been treated for diabetes?	a.	☐	☐
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.	☐	☐
b. Describe condition:	b.	_____	
c. Describe current medication and dosage, if any, under "remarks."			
d. Do you have a pacemaker?	d.	☐	☐
e. Date of last treatment or check-up:	e.	_____	
6. Epilepsy:			
a. Have you ever been treated for epilepsy?	a.	☐	☐
b. If "Yes," when was your last seizure?	b.	_____	
c. Describe current medication and dosage, if any, under "remarks."			

Remarks:

NOTE: If any questions 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:

	Yes	No
7. Blood Pressure:		
a. Have you ever been treated for high blood pressure? ..... a.	☐	☐
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.	☐	☐
b. Have you lost the use of an arm or leg? ..... b.	☐	☐
c. Does vehicle have special controls? ..... c.	☐	☐
d. If "Yes" to any of the above, describe under "remarks."		
9. Miscellaneous:		
a. Have you ever had, or been treated for, Convulsions? ..... a.	☐	☐
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.	☐	☐
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.	☐	☐
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.	☐	☐
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.	☐	☐
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?	☐	☐
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?	☐	☐

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:** _____

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

"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.

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

_____ _____

Signature of Person Named Above **Date**