LITTLE SILVER VOLUNTEER DEPARTMENT

ACTIVE FIREFIGHTER APPICATION INSTRUCTIONS

ITEMS UNDERLINED ARE REQUIRED BY YOUR DOCTOR

1. COMPLETE LITTLE SILVER FIRE DEPARTMENT APPICATION FOR MEMBERSHIP.
2. REPORT TO LITTLE SILVER POLICE DEPARTMENT TO BE FINGERPRINTED FOR CRIMINAL BACKROUND CHECK.
3. COMPLETE FIRE COMPANY OATH OF OFFICE.
4. COMPLETE NEW JERSEY STATE FIREMAN'S RELIEF ASSOCIATION APPLICATION.
    a. MUST BE NOTORIZED AND PHYSICAL EXAM MUST BE WITHIN 180 DAYS OF THE APPLICATION.
5. COMPLETE FIREFIGHTER 1 REGISTRATION FORM FOR ACADEMY DETERMINDED BY FIRE CHIEF ALONG WITH PAPERWORK REQUIRED FOR SAID ACADEMY.
    a. LETTER FROM PHYSICIAN STATING YOU ARE PHYSICALLY FIT TO ATTEND THE FIRE ACADEMY.
6. COMPLETE OSHA RESPIRARTOR MEDICAL EVALUATION QUESTIONAIRE AND SUBMIT TO DOCTOR. A LETTER FROM YOUR DOCTOR CLEARING YOU TO WEAR A RESPIRATOR IS REQUIRED.
7. SCHEDULE A TIME WITH A FIRE OFFICER TO COMPLETE PROBABTIONARY PHYSICAL ABILITY TEST.
8. SUBMIT THE FINALIZED APPLICATION TO THE FIRE CHIEF OR HIS DESIGNEE.

THE FIRE COMPANY HOLDS MEETINGS ON THE FIRST THURSDAY OF EVERY MONTH AT 8 PM. YOUR APPLICATION WILL BE READ AT THE FIRST MEETING AND YOU WILL BE SWORN IN AT THE FOLLOWING MONTH'S MEETING PENDING THE OUTCOME OF YOUR BACKROUND CHECK.

APPLIATION RECEIVED DATE:________________________________

RECEIVED BY:____

LITTLE SILVER FIRE DEPARTMENT APPLICATION FOR MEMBERSHIP

ALL APPLICANTS MUST BE FINGERPRINTED. CALL LSPD FOR APPOINTMENT.

PLEASE DROP OFF APPLICATION IN THE FIREHOUSE MAILBOX (PARKING LOT) IN A SEALED ENVELOPE ADDRESSED NEW MEMBER APPLICATION.

PLEASE CIRLCE ONE: ACTIVE FIRE POLICE LADIES AUXILARY SOCIAL

LAST NAME: ______________________ FIRST NAME: ____________________ INITIAL: ___

CURRENT ADDRESS: ____________________________ TOWN: ______________________

HOME PHONE: _________________________ OTHER PHONE: ______________________

IF LESS THAN TWO (2) YEARS AT CURRENT ADDRESS LIST PRIOR ADDRESS BELOW:

STREET ADDRESS: ___________________________ TOWN: _______________________

S.S.N. _______________ EMPLOYER: ____

OCCUPATION: ____

EMPLOYER ADDRESS: ____

EMPLOYER TELEPHONE: __________________ NORMAL WORK HOURS _______________.

LIST ANY PREVIOUS FIREFIGHTING EXPERIENCE:

F.D. NAME: ______________________________ F.D. PHONE # ____________________

ATTACH COPIES OF ANY FIREMATIC TRAINING CERTIFICATES

PROVIDE NAME, ADDRESS AND TELEPHONE OF TWO (2) PERSONAL REFERENCES WHO ARE NOT RELATIVES OR EMPLOYERS:

1-____

2-____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO

ARE YOU AVAILABLE TO RESPOND DURING THE DAY TIME? YES NO

SIGNATURE OF APPLICANT ____

COMPANY PRESIDENT SIGNATURE DATE: ____________________________________

FIRE CHIEF SIGNATURE & DATE: _______________________________________

BACKGROUND CHECK COMPLETED BY P.D.: ________________________________

Fire Company Oath Of Office

I,_________________________ do hereby solemnly promise that I will uphold the Constitution, By-Laws and dignity of the Little Silver Volunteer Fire Company No. 1 and will give my time and ability to work for its benefit, so help me God.

Signature ______________________________

I, _________________________, have received from:

Equipment	Member & Date	Officer & Date
Radio, Serial # ___________		
Jacket		
Hat Badge # __________		
Uniform Badge # ________		
Uniform		
Copy of Constitution & By-Laws		
Fire House key # _________		
Other:		
Other:		
Other:		

MIDDLETOWN TOWNSHIP FIRE DEPARTMENT
TRAINING ACADEMY
1 KINGS HIGHWAY
MIDDLETOWN, NJ 07748
732-615-3280 / 732-957-9369 (FAX)
WWW.MIDDLETOWNFIREACADEMY.COM

FIREFIGHTER I RECRUIT REGISTRATION FORM

Instructions: Complete entire form and return to the Training Academy.

Additional Documentation: Firefighter recruits must receive medical clearance to participate in firefighter training and firefighting activities. A letter stating that the recruit has been examined by a licensed healthcare professional must accompany this application.

Proof of age: The minimum age for certification is 18. A copy of the applicant's driver's license or birth certificate must accompany this application.

Registration is on a first come basis. The Academy reserves the right to allow entry to M.T.F.D. prior to others. Class size is limited to 25 recruits. Classes are scheduled for Tuesday & Thursday evenings from 1900-2200 hours and Saturdays from 0800-1600 hours.

First Name M Last Name

Date of Birth Age NJ DFS FFID# Email

Phone (H) Phone (M) Phone (W)

Address City Zip

Company Department

Height Weight Shirt Size Waist Size

Company/Department Contact Phone

Candidate Signature Application Date

This form must be approved by a Company/Department Officer

I attest that the applicant is a member of the above Fire Company, has successfully completed all prerequisites and is covered by Workers' Compensation and Liability Insurance.

Officer Name (Print) Title

Officer Signature Date

ACADEMY USE ONLY

Date Received Received By Enrollment Confirmed

★LEADERSHIP★SERVICE★INSTRUCTION★

Legible copy of driver's license & physical clearance form <u>must</u> accompany this application

MONMOUTH COUNTY FIRE ACADEMY
1027 Highway 33 East
Freehold, NJ 07728
Telephone 732-683-8857 / Fax 732-683-8978
William Itinger, Chief Training Officer
witinger@co.monmouth.nj.us
www.monmouthcountyfireacademy.org

Firefighter I Candidate Registration Form

Instructions: Fill in form entirely, print and fax to the academy. Incomplete forms will be rejected.

Required age is 18. Registration will be on a first come basis with preference given to Monmouth County registrants. Classes are held on Tuesday and Thursday evenings at 7 PM and Saturday and Sunday mornings at 8 AM. Plan on arriving 15 minutes prior to class time. Be prepared for each class – refer to the requirements listed on student syllabus. A copy of candidate's Driver's License & physical clearance **must** accompany this application.

Candidate:

Class Preference: _______ **Tuesday/Saturday** _______ **Thursday/Sunday** _______ **No Preference**

Name____ D. O. B. ________________ Age______

SS# ____________________ Phone (H) ______________________ (C) ______________________

Street Address: ____

City: ____ State: ________ Zip ______________

Fire Department /Company____________________________________ Station # __________

Department Address ____

Department/Company Contact ____________________________ Phone # ________________

Emergency Contact ___________________________________ Phone # ________________

Candidate Signature __________________________________ Date ___________________

Candidate E-mail Address____

Verification/Authorization:

______ Fire Department History

______ Response area of Department

______ Standard Operating Procedures

______ Exposure Control Plan

______ RTK Station Walk-through

______ Department Equipment Familiarization

______ Written recommendation regarding the recruits ability to use an SCBA from PLHCP

______ Organization Structure

______ Candidate duties & Responsibilities

______ NJ Right to Know

______ OSHA PPE

______ Station ID Number

I attest that the candidate is a member of the above Fire Company/Department, has successfully completed all prerequisites listed above and is covered by Workers' Compensation and Liability Insurance.

Name______________________________ Title ____________________ Date __________

Phone # ______________________ E-mail Address ____________________________________

Signature____

Academy Use:

Date Received ____________ Received By _______ _______ D.O.B Verified By _______

OSHA Respirator Medical Evaluation Questionnaire

Can you read (check one): Yes ☐ No ☐

The following information must be provided by every individual who has been selected to use any type of respirator (please print).

Name: ______________________ Date: ______________

Job Title: ______________________

Department: ______________________

Supervisor: ______________________

Social Security Number (for Health Services records only): ______________

Date of Birth:: ______________

Sex (check one): Male ☐ Female ☐

Height: ________ ft. ________ in. Weight: ________ lbs.

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the *area code*): ______-______- ______

The best time to phone you at this number: ________

Has your employer told you how to contact the health care professional who will review this questionnaire (check one):

Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

- ☐ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
- ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Do you have any of the following conditions which could affect respirator fit?

☐ Clean Shaven	☐ Facial Scar
☐ 1-2 Day Growth	☐ Dentures Absent
☐ 2+ Day Growth	☐ Glasses
☐ Mustache	☐ None

Comments: ______________________

Have you worn a respirator before? (check one):

Yes ☐ No ☐

If "Yes," what type(s): ______________________________

The questions below must be answered by every individual who has been selected to use any type of respirator (please check "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?

Yes ☐ No ☐

2. Have you **ever had** any of the following conditions?

Yes ☐ No ☐ Seizures (fits)
Yes ☐ No ☐ Diabetes (sugar disease)
Yes ☐ No ☐ Allergic reactions that interfere with your breathing
Yes ☐ No ☐ Claustrophobia (fear of closed-in places)
Yes ☐ No ☐ Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes ☐ No ☐ Asbestosis
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Chronic bronchitis
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Pneumonia
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Silicosis
Yes ☐ No ☐ Pneumothorax (collapsed lung)
Yes ☐ No ☐ Lung cancer
Yes ☐ No ☐ Broken ribs
Yes ☐ No ☐ Any chest injuries or surgeries
Yes ☐ No ☐ Any other lung problem that you've been told about

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

- Yes ☐ No ☐ Shortness of breath
- Yes ☐ No ☐ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
- Yes ☐ No ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
- Yes ☐ No ☐ Have to stop for breath when walking at your own pace on level ground
- Yes ☐ No ☐ Shortness of breath when washing or dressing yourself
- Yes ☐ No ☐ Shortness of breath that interferes with your job
- Yes ☐ No ☐ Coughing that produces phlegm (thick sputum)
- Yes ☐ No ☐ Coughing that wakes you early in the morning
- Yes ☐ No ☐ Coughing that occurs mostly when you are lying down
- Yes ☐ No ☐ Coughing up blood in the last month
- Yes ☐ No ☐ Wheezing
- Yes ☐ No ☐ Wheezing that interferes with your job
- Yes ☐ No ☐ Chest pain when you breathe deeply
- Yes ☐ No ☐ Any other symptoms that you think may be related to lung problems

5. Have you **ever had** any of the following cardiovascular or heart problems?

- Yes ☐ No ☐ Heart attack
- Yes ☐ No ☐ Stroke
- Yes ☐ No ☐ Angina
- Yes ☐ No ☐ Heart failure
- Yes ☐ No ☐ Swelling in your legs or feet (not caused by walking)
- Yes ☐ No ☐ Heart arrhythmia (heart beating irregularly)
- Yes ☐ No ☐ High blood pressure
- Yes ☐ No ☐ Any other heart problem that you've been told about

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

- Yes ☐ No ☐ Frequent pain or tightness in your chest
- Yes ☐ No ☐ Pain or tightness in your chest during physical activity
- Yes ☐ No ☐ Pain or tightness in your chest that interferes with your job
- Yes ☐ No ☐ In the past two years, have you noticed your heart skipping or missing a beat
- Yes ☐ No ☐ Heartburn or indigestion that is not related to eating
- Yes ☐ No ☐ Any other symptoms that you think may be related to heart or circulation problems

7. Do you **currently** take medication for any of the following problems?

Yes ☐	No ☐	Breathing or lung problems
Yes ☐	No ☐	Heart trouble
Yes ☐	No ☐	Blood pressure
Yes ☐	No ☐	Seizures

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9) :

Yes ☐	No ☐	Eye irritation
Yes ☐	No ☐	Skin allergies or rashes
Yes ☐	No ☐	Anxiety
Yes ☐	No ☐	General weakness or fatigue
Yes ☐	No ☐	Any other problem that interferes with your use of a respirator

☐ Check here if you have never used a respirator.

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Yes ☐ No ☐

Questions 10 to 15 below must be answered by every individual who has been selected to use either a **full-face piece respirator or a self-contained breathing apparatus (SCBA)**. For individuals who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever** lost vision in either eye (temporarily or permanently)? Yes ☐ No ☐

11. Do you **currently** have any of the following vision problems?

Yes ☐	No ☐	Wear contact lenses
Yes ☐	No ☐	Wear glasses
Yes ☐	No ☐	Color blind
Yes ☐	No ☐	Any other eye or vision problem

12. Have you **ever had** an injury to your ears, including a broken ear drum? Yes ☐ No ☐

13. Do you **currently** have any of the following hearing problems?

Yes ☐ No ☐ Difficulty hearing
Yes ☐ No ☐ Wear a hearing aid
Yes ☐ No ☐ Any other hearing or ear problem

14. Have you **ever had** a back injury?

Yes ☐ No ☐

15. Do you **currently** have any of the following musculoskeletal problems?

Yes ☐ No ☐ Weakness in any of your arms, hands, legs, or feet
Yes ☐ No ☐ Back pain
Yes ☐ No ☐ Difficulty fully moving your arms and legs
Yes ☐ No ☐ Pain or stiffness when leaning forward/backward at the waist
Yes ☐ No ☐ Difficulty fully moving your head up or down
Yes ☐ No ☐ Difficulty fully moving your head side to side
Yes ☐ No ☐ Difficulty bending at your knees
Yes ☐ No ☐ Difficulty squatting to the ground
Yes ☐ No ☐ Climbing a flight of stairs or a ladder carrying 25 lbs +
Yes ☐ No ☐ Any other muscle or skeletal problem that interferes with using a respirator

d. To be accepted for Probationary Membership, the applicant must meet the following standards:

(1) The applicant must be a resident of the Borough of Little Silver or work full time within the Borough for at least thirty (30) hours per week or a fire fighter that lives in one of the five (5) contiguous towns bordering the Borough and be at least 18 years of age.

(2) The applicant must satisfactorily pass a minimum physical ability test administered under the supervision of the Investigating Committee. The test will be conducted with the applicant fully dressed with normal fire fighting equipment (hat, coat and boots) and the applicant shall satisfactorily perform each of the following, after being fully instructed as to the manner in which the tests are to be performed:

(a) Drag two fifty (50) foot lengths of two and one-half (2 ½) inch fire hose a distance of twenty-five (25) yards.

(b) Uncouple the same two lengths of hose and roll one of them.

(c) Carry one rolled fifty (50) foot length of two and one-half (2 ½) inch fire hose a distance of twenty-five (25) yards and place the rolled length on a fire truck bed.

(d) Wearing an air pack in the prescribed manner but with no air mask and carrying a fifteen (15) pound type fire extinguisher, climb the stairs to the second floor of a building and return down same.

(e) Remove a fourteen (14) foot ladder from a truck and carry it once around the truck and replace it on same.

(f) Remove the compartment fan and cord from a truck and carry both at one time once around the truck and replace same as found.

(3) The applicant shall not have been convicted of any crime or other offense which would, in the opinion of the Investigation Committee, adversely reflect on the applicant's ability to perform as a Member of the Company nor shall there be any other past conduct on the applicant's part which would indicate the absence of the good character and honestly required of Members of the Company.