

Training

Have you ever belonged or do you belong to another Fire Co or Ambulance Assoc Yes___ No___

Name of Company

Phone#

Date of Leaving

List any special training you received in fire fighting, chemistry, Hazardous Materials, safety, medical, communications, computer, driving, police, etc:

Have you ever been refused membership to any Fire Company or EMS association? Yes No

If yes please give a brief statement explaining why:

References: (Give the names of THREE persons NOT related to you, whom you have known at least 1 year)

	<u>Name</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Yrs. Known</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Have you ever been convicted of violating any criminal laws (other than traffic).

Yes No

If yes, list offense, where, and final disposition of the offense:

By signing this document, I am swearing or affirming that the information above is true and correct to the best of my knowledge. I understand that any falsification or deception of any kind of the above information may be grounds for my membership not being approved or dismissal from the team.

Signature: _____ Date: _____

Medical:

Pre Physical Questionnaire

Family Doctor: _____ Phone: _____

Allergies: _____

Emergency Contact Person:

Name: _____

Phone Number: _____

Relationship: _____

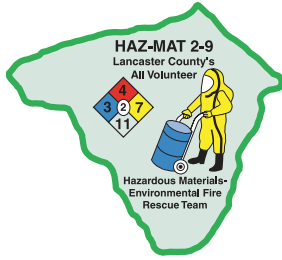
Have you had or do you have medical problems with any of the following:

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Back | <input type="checkbox"/> TB | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Eye Sight |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Nose | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Glands or Ears | <input type="checkbox"/> Liver | <input type="checkbox"/> Rectum |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Disease of the Bones | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Pain in Feet / Legs |
| <input type="checkbox"/> Disease of Brain or Central Nervous System | | | | |

If any of the above is checked, give a brief statement of what, when, treatment & who treated you:

Have you ever been turned down for life insurance? Yes No

If yes, give a brief statement explaining why:



HAZMAT 2-9 ENVIRONMENTAL FIRE RESCUE TEAM

P.O. Box 8004 - Lancaster, PA 17604 • (717) 537-4197

HAZ MAT 2-9

Release Form

By signing this page, I am giving permission to members of HazMat 2-9 or any of its agents to look into my background. I give permission for release of any medical records, criminal records, and driver's license records to HazMat 2-9 or its agents. I give permission to HazMat 2-9 or its agents to contact my employer; references and other fire companies or EMS associations that I once belonged to or currently belong to, for the purpose of looking into my background.

Print Name _____

Signature: _____

Date: _____

