STONEY POINT FIRE DEPARTMENT

Application for Membership & Employment

(Version – January 2016)

1st Meeting _____ 2nd Meeting _____ 3rd Meeting _____ 4th Meeting _____

INSTRUCTIONS TO APPLICANTS

TO BE CONSIDERED FOR SPFD EMPLOYMENT, YOU MUST ANSWER ALL QUESTIONS AND COMPLETE ALL SECTIONS OF THIS APPLICATION FORM.

STONEY POINT EMPLOYS ONLY US CITIZENS OR ALIENS WHO CAN PROVIDE PROOF OF IDENTITY AND WORK AUTHORIZATION WITHIN 3 WORKING DAYS OF EMPLOYMENT. MALES SUBJECT TO MILITARY SELECTIVE SERVICE REGISTRATION MUST CERTIFY COMPLIANCE TO BE ELIGIBLE FOR SPFD EMPLOYMENT (G.S. 143B-421.1). SEE AVAILABILITY BLOCK.

WHEN COMPLETING THIS APPLICATION, PLEASE MAKE SURE YOU

- COMPLETE THE SECTION FOR EQUAL OPPORTUNITY INFORMATION.
- GIVE COMPLETE INFORMATION ON YOUR EDUCATION AND WORK HISTORY ("SEE RESUME" IS NOT ACCEPTABLE).
- LIST SEPARATELY EACH JOB HELD AND YOUR DUTIES FOR EACH POSITION WHEN YOU WORKED FOR ONE EMPLOYER AND HELD MORE THAN ONE POSITION.
- PROVIDE ONLY THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER.
- CHECK FOR ACCURACY, SIGN AND DATE YOUR APPLICATION.
- ATTACH A CERTIFIED LOCAL RECORDS CHECK FROM YOUR COUNTY OF RESIDENCE – IF YOU HAVE RESIDED IN NC LESS THEN TWO (2) YEARS ATTACH A CERTIFIED LOCAL RECORDS CHECK FROM YOUR LAST STATE/COUNTY OF RESIDENCE, OR BOTH.

THANK YOU FOR YOUR INTEREST IN PUBLIC SERVICE. THE STONEY POINT FD WANTS TO FIND THE BEST QUALIFIED PEOPLE AVAILABLE TO SERVE OUR COMMUNITY & CITIZENS. ALTHOUGH EVERYONE WHO APPLIES CANNOT BE HIRED OR ACCEPTED, YOUR APPLICATION WILL BE GIVEN EVERY CONSIDERATION.

Equal Opportunity Information

Government policy prohibits discrimination based on race, sex, color, creed, national origin, age or disability. Sex, age or absence of disability is a bona fide occupational qualification in some fire department jobs. The information requested below will in no way affect you as an applicant. Its sole use will be to see how well our recruitment efforts are reaching all segments of the population.

Date of Birth

_____
(Month) (Day) (Year)

Gender

☐ Male ☐ Female

DISABILITY: "Disability means, with respect to an individual: (1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment" (Americans with Disabilities Act of 1990). Persons without a disability should check item A. The reporting of a **disability is strictly VOLUNTARY**. Persons with disabilities who **DO NOT WISH** to report their disabilities should check item A. Information reported on this form will be kept confidential as required by State law. Public disclosure of this information without your consent would be a violation of NC G.S. 126-27.

ETHNIC GROUP

1. ☐ White (non-Hispanic)
2. ☐ Black (non-Hispanic)
3. ☐ Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, other Spanish origin regardless of race)
4. ☐ Asian (including Pacific Islander)
5. ☐ American Indian (including Alaskan native)

A ☐ None/Prefer not to report
B ☐ Blind or severely visually impaired
C ☐ Deaf or severely hearing impaired
D ☐ Loss of limited use of arms and/or hands
E ☐ Non-ambulatory (must use wheelchair)
F ☐ Other orthopedic impairment (including amputation, arthritis, back injury, cerebral palsy, spina bifida, etc.)
G ☐ Respiratory impairment
H ☐ Nervous system/Neurological disorder
I ☐ Mentally restored
J ☐ Mental retardation
K ☐ Learning disability
L ☐ Others (heart disease, diabetes, speech impairment)
M ☐ Other (please specify)

_____

APPLICATION FOR MEMBERSHIP & EMPLOYMENT

STONEY POINT FIRE DEPARTMENT

Date of Application			
Last 4 digits of Social Security No.	Last Name	First Name	Middle Name
Address (Street number and name)		City	County
State	Zip Code	Phone (Home or where you can be reached)	Business Phone

Availability
Do you now work for the SPFD?
☐ YES ☐ NO

Are you related by blood or marriage to any person now working for the SPFD ☐ YES ☐ NO
If yes, give name, relationship to you and the agency where employed.

SPFD is an at-will employment entity in which all full/part time FF/EMT applicants must sign an acknowledgement of conditional employment conditions (Attached)!

Military Service
Have you served honorably in the Armed Forces of the United States on active duty for reasons other than training? ☐ YES ☐ NO

Do you wish to declare a service-connected disability? ☐ YES ☐ NO

If you have served in the United States Armed Forces please provide the following information.

Entered: _____ Separated: _____ Branch: _____ Rank _____

Are you a member of the Military Reserves? ☐ YES ☐ NO Branch: _____ Rank: _____

List Reserve Unit & Address:

CHECK the types of work you will accept: ☐ 1. Vol. Firefighter/EMT ☐ 2. Volunteer Auxiliary ☐ 3. Volunteer Support ☐ 4. Board of Director

☐ 5. Full Time FF/EMT ☐ 6. Part Time FF/EMT ☐ 7. Junior Firefighter's Program

If you are not available for work now, enter the earliest date you could begin work (mo/day/yr.)_____

If accepted as a volunteer, full or part time, can you furnish proof you are eligible to work in the United States: Yes ☐ No ☐

If applying for a full time position are you willing to work 24 hour shift work: Yes ☐ No ☐

Volunteer Firefighter / EMT positions require minimum overnight stays at either SPFD Station. Are you willing to participate in overnight duty shifts: Yes ☐ No ☐

Referral Source
Please indicate your referral source: _____
(Walk In, friend, paper, call in etc)

Education
Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 Graduate School 1 2 3 4
Under S/Q Hrs., list the hours of credit received and if they were semester (S) or quarter (Q) hours.

Schools	Name and Location	Dates Attended (mo/yr) From: To:	Grad?	S/Q Hrs.	Major/Minor Course Work	Type of Degree Received
High School			YES ☐ NO ☐			
College(s) University (s)			YES ☐ NO ☐			
Graduate or Professional			YES ☐ NO ☐			
Other educational, vocational school, internships, etc.			YES ☐ NO ☐			

Special training programs and seminars you have completed in the last five years (list):

If the job(s) applied for calls for specific courses, indicate those courses taken and credits received:

Current professional status: (List fields of work for which you have been registered)
Registration: _____ State: _____ No. _____
Registration: _____ State: _____ No. _____

Membership in professional, honorary, or technical societies (list):

DO NOT COMPLETE THIS BLOCK
DEGREES AND PROFESSIONAL CREDENTIALS
☐ Have been verified
☐ Will be verified within 90 days (G.S. 126-30)
Person Responsible:

Licenses and certifications (List, giving dates and sources of issuance):

SKILLS

CHECK the following skills, experiences, etc., which you have:

- ☐ Driver's License _____ (Number) _____ (State)
- ☐ Chauffeur's License _____ (Number) _____ (State)
- ☐ Car for use at work
- ☐ Sign Language
- ☐ Foreign language (specify) _____
- ☐ Adding Machine/calculator
- ☐ Typing (specify WPM) _____
- ☐ Shorthand/speedwriting (specify WPM) _____
- ☐ Legal transcription
- ☐ Medical transcription
- ☐ Braille
- ☐ Word Processing
- ☐ Other _____

Have you ever been convicted of an offense against the law other than a minor traffic violation? (A conviction does not mean you cannot be hired. The offense and how recently you were convicted will be evaluated in relation to the job for which you are applying.) ☐ YES ☐ NO (If yes, explain fully on an additional sheet.)

WORK HISTORY (include volunteer experience) Use Additional Sheets if Necessary (Salary Information is not required for Volunteer Positions)

Current or Last Employer:		Address:		
Job Title:		Supervisor's Name	Telephone Number	No. Supervised by you:
Date Employed (mo/yr)	Starting Salary $ per	Ending or Current Salary $ per	Reason for Leaving	May We Contact Employer YES ☐ NO ☐
Date Separated (mo/yr)	List major duties in order of their importance in the job:			
Full Time Years Months				
Part Time Years Months				
If part time, number of hours worked per week:				

Employer:		Address:		
Job Title:		Supervisor's Name	Telephone Number	No. Supervised by you:
Date Employed (mo/yr)	Starting Salary $ per	Ending or Current Salary $ per	Reason for Leaving	
Date Separated (mo/yr)	List major duties in order of their importance in the job:			
Full Time Years Months				
Part Time Years Months				
If part time, number of hours worked per week:				

Employer:		Address:		
Job Title:		Supervisor's Name	Telephone Number	No. Supervised by you:
Date Employed (mo/yr)	Starting Salary $ per	Ending or Current Salary $ per	Reason for Leaving	
Date Separated (mo/yr)	List major duties in order of their importance in the job:			
Full Time Years Months				
Part Time Years Months				
If part time, number of hours worked per week:				

I certify that I have given true, accurate and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information or documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed, and (or) criminal action. I further understand that dismissal upon employment shall be mandatory if fraudulent disclosures are given to meet position qualifications (Authority: NC G.S. 126-30, G.S. 14-122.1.)

_____ _____

Signature of Applicant (unsigned applications will not be processed) Date

THIS FORM APPLIES TO FULL/PART TIME PAID POSITIONS ONLY

ACKNOWLEDGEMENT OF CONDITIONAL EMPLOYMENT

The **Stoney Point Fire Department, Inc**. is an at-will employment entity from which any employee may be discharged with or without cause at the discretion of the employer. However, in furtherance and supplementation of this general policy, the Stoney Point Fire Department, Inc. wants its new hires who have not met all of the criteria for full employment (even if it is only at-will employment), or whose job requirements require continuing certification as to certain abilities, both physical and technical, that they are retained under very specific conditions of employment. Those specific conditions of employment, above and beyond the normal conditions of employment, are as follows:

1. Within one (1) year of employment, an employee hired as a Firefighter/EMT must obtain and maintain a North Carolina State Firefighter II Certification and a North Carolina Basic Emergency Medical Technician Certification.

2. Within one (1) year of employment, an employee hired as a Firefighter/EMT must meet and maintain all of the physical fitness requirements set forth by the Fire Department for this position, such as 2 mile run, push-ups, sit ups, and be able to bench press his/her weight. Physical Fitness Standards are based on established Military (Army) Physical Fitness Standard for the before mentioned categories based on sex and age where 60% is considered passing.

3. Employee recognizes and acknowledges he or she is an at-will employee, at all times, of the Stoney Point Fire Department, Inc.

I hereby certify that I have read, understand and agree to the above stated special conditions related to conditional employment as a Firefighter/EMT for the Stoney Point Fire Department, Inc.

Date: _____ _____

EMPLOYEE

Date: _____ _____

WITNESS

THIS FORM DOES NOT APPLY TO VOLUNTEER MEMBERSHIP POSITIONS

(Enclosure # 1 – SPFD Application for Membership & Employment)

SPFD IamResponding.com (IAR) – INFORMATION SHEET – (2016 Version)

LAST FOUR SSAN: _____

FIRST & LAST NAME (print) _____

PRIMARY E-MAIL ADDRESS _____

CELL PHONE NUMBER (area code & #) _____

CELL PHONE CARRIER - _____

WORK TELEPHONE # _____

HOME TELEPHONE # _____

COMPLETE ADDRESS & Zip Code: _____

_____

DATE OF BIRTH: _____

DATE JOINED :(Todays Date)_____ _____

EMERGENCY CONTACT # 1 (Name) _____

Relationship:_____

Primary Phone #_____

EMERGENCY CONTACT # 2 (Name) _____

Relationship:_____

Primary Phone #_____

Beneficiary Designation for Accident & Sickness Policy

Complete this section each time this form is used—Please Print

Name of Organization STONEY POINT FIRE DEPARTMENT INC. State N.C.

Member's/Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this section if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please see below for examples)

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____%

Name _____ Relationship _____ Date of Birth _____ Share _____%

Contingent Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____%

Name _____ Relationship _____ Date of Birth _____ Share _____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ **Date** _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

Specifying Beneficiaries

Individual (always show relationship to the insured)	***Primary Beneficiary**	****Contingent Beneficiary**	Second **Contingent Beneficiary**
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

VFIS
A Division of Glatfelter Insurance Group

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. _____

REMARKS: If any question 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.

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

2. Eyesight:	**Yes**	**No**
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."		

Questions:

REMARKS:

	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:** _____

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, to give _____ _____ Department/Company any such information."

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

_____ _____

Signature of Person Named Above **Date**

PERSONAL DATA FORM

LAST NAME:	DRIVERS LIC # AND STATE:
FIRST NAME:	EXPIRES:
MIDDLE:	D/L CLASS:
LAST FOUR SS#:	D/L RESTRICTIONS:
ADDRESS:	MARITAL STATUS:
CITY:	SPOUSE NAME:
ZIP:	SPOUSE EMPLOYMENT:
MILES TO STATION:	COUNTY OF RESIDENCE:
DATE OF BIRTH:	PHYSICIAN:
HOME PHONE:	HOSPITAL PREFERENCE:
WORK PHONE:	DENTIST:
CELL PHONE:	RELIGION:
EMAIL ADDRESS:	HEIGHT:
EMERGENCY CONTACT:	WEIGHT:
RELATION:	HAIR COLOR:
CONTACT EMPLOYMENT:	HAIR STYLE:
ADDRESS	EYE COLOR:
CITY, STATE, ZIP:	RACE:
HOME PHONE:	BODY MARKINGS:
WORK PHONE:	CONTACTS Y/N:
CELL PHONE:	ORGAN DONOR Y/N:
EMERGENCY CONTACT (2):	TOBACCO USER Y/N:
RELATION:	TOBACCO USE:
CONTACT EMPLOYMENT:	ALLERGIES:
ADDRESS:	MEDICATIONS:
CITY,STATE, ZIP:	MEDICAL CONDITIONS:
HOME PHONE:	YEAR GRADUATED HIGH SCHOOL:
WORK PHONE:	COLLEGE DEGREES:
CELL PHONE:	EMPLOYER:
SOCIAL SECURITY NUMBER:	SHIFT HOURS:
VETERAN Y/N:	POSITION:
STATION USE ONLY:	
EFFECTIVE DATE:	WEEKNIGHT SHIFT: STATION: