

APPLICATION FOR PROBATIONARY FIREFIGHTER (Page 1 of 6)

** All information and references given on the application may be verified by the Fire Chief/Administrator of the organization*

Name: _____ **Date:** _____
Home Address: _____ **Local Address:** _____

Phone Number: _____ **E-Mail:** _____
DOB: _____ **SSN:** _____
(Federal Law Prohibits Age Discrimination)

Emergency Notification

Name: _____ **Phone (day):** _____ **Phone(evening):** _____
Address: _____
Beneficiary (Relationship): _____

Please note, the fire department enters many homes, businesses, and occupancies during times of crisis. The public places great trust in the integrity of the fire department. It is possible during your membership or application period a background check may be initiated to validate your responses on the next page. Your signature here indicates your understanding of this and gives the Chief of the Department the permission to conduct a background check.

Signature: _____ **Date:** _____
If under 18, a parent/guardian signature is required and applicant must contact Chief Barrington.

GENERAL RELEASE

KNOW ALL MEN, THAT I _____, OF THE TOWN OF _____ County of _____, do hereby AUTHORIZE The Kingston Fire District, its agents and employees to obtain the following information about me:

1. Drivers License Check
2. EMT License Check
3. Criminal Background Check

I hereby authorize any agency, organization or person in possession of such information about me, to release said information to the Kingston Fire District and agree to release the Town of South Kingstown, Kingston Fire District and/or the Police Department of South Kingstown, its officers, agents, and employees, and any organization, agency or person providing such information from any liability resulting from an investigative background check for the position of Volunteer Fire Fighter of the Kingston Fire District.

Signature: _____ **Date:** _____

(Do Not Write Below this Line)

In Witness Whereof, the said _____ has caused these presents to be signed, acknowledged and delivered in his/her name on the _____ day of _____ 20__

Notarized _____ Commission expires: _____

Date reviewed by Chief _____
 cc: Deputy Chief (original page 1) _____
 Date forwarded to Membership Committee _____
 Date Probationary Checklist Completed: _____
 Date Off Probation: _____

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Name: _____ Date: _____

Driver's License Number and State: _____

Driver's License Class and Expiration Date: _____

Current Employment or Name of School: _____

Background Investigation:

Have you ever had your Driver's License revoked or suspended? Yes No

Have you ever been arrested? Yes No

(If yes, please attach letter outlining the circumstances and outcome)

Have you ever been disabled from a job? Yes No

(If yes, please attach letter outlining the circumstances and outcome)

Educational background:

High School/Tech School: _____

College/Vocational School: _____

Post Graduate: _____

Previous Firefighting/ESO Experience:

Fire Company/ESO: _____ Date: _____ Rank: _____

Fire Chief's/Administrator's Name: _____ Phone #: _____

Fire Company/ESO: _____ Date: _____ Rank: _____

Fire Chief's/Administrator's Name: _____ Phone #: _____

Have you worked on a HAZMAT team? Yes No

Total years involved in FF/ESO: _____

Fire Schools/Training (Firefighters/Rescue, EMS, etc. – please include certificates, certifications and contact names for verification)

1. _____
2. _____
3. _____
4. _____
5. _____
7. _____

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Name: _____ Date: _____

Previous/Current Occupation, Hobbies, Experience:

Have you ever been in the military service? **Yes** **No**

If yes...

Were you exposed to biological or chemical agents? (training or combat) **Yes** **No**

List your current and/or previous occupation: _____

List any second jobs or side business you have: _____

List your current and previous hobbies: _____

Health Information:

Current Physician: Name: _____ Tel: _____
Address: _____
Address: _____

Date of last physical: _____

Do you have any allergies to medications, insect bites, or anything that would be harmful to you if exposed? _____

Please list any surgeries/operations: _____

Do you have any major illnesses? _____

Do you currently smoke tobacco, or have you smoked tobacco in the last month? **Yes** **No**

1. Have you had any of the following conditions?

- Seizures (convulsions) **Yes** **No**
- Diabetes **Yes** **No**
- Allergic reactions that interfere with your breathing **Yes** **No**
- Claustrophobia (fear of being closed in places) **Yes** **No**
- Trouble smelling odors **Yes** **No**

2. If you have used a respirator, have you ever had any of the following problems?

- Eye irritation **Yes** **No**
- Skin allergies **Yes** **No**
- General weakness **Yes** **No**
- Any other problems that interferes with the use of a respirator **Yes** **No**
- Anxiety **Yes** **No**

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Name: _____ Date: _____

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

- Asbestos Yes No
- Asthma Yes No
- Chronic Bronchitis Yes No
- Emphysema Yes No
- Pneumonia Yes No
- Tuberculosis Yes No
- Silicosis Yes No
- Pneumothorax Yes No
- Lung Cancer Yes No
- Broken Ribs Yes No
- Any chest injuries or surgeries Yes No
- Any other lung problems you are aware of Yes No

4. Do you currently have any of the following symptoms?

- 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 that interferes with your job Yes No
- Shortness of breath when washing or dressing yourself Yes No
- Coughing that produces phlegm (think sputum) Yes No
- Coughing that wakes you up early in the morning Yes No
- Coughing up blood within the last month Yes No
- Coughing that occurs mostly when you are lying down Yes No
- Wheezing Yes No
- Wheezing that interferes with your job Yes No
- Chest pain when you breathe deeply Yes No
- Other symptoms that you think may be related to lung problems Yes No

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

- 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 problems that you are aware of Yes No

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

- 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
- 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 your heart or circulation problems Yes No

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Name: _____ **Date:** _____

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

- Breathing or lung problems Yes No
- Heat trouble Yes No
- Blood Pressure Yes No
- Seizures Yes No

Please explain any conditions you have entered yes to for the following questions:

8. Would you like to talk to the Fire Chief who will review this questionnaire about your answers? Yes No

9. Have you ever lost vision in either eye? Yes No

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

- Wear contact lenses Yes No
- Wear eye glasses Yes No
- Color Blind Yes No
- Any other eye or vision problems Yes No

11. Have you ever had an injury to your ears including a ruptured eardrum? Yes No

12. Do you currently have any of the following problems?

- Difficulty hearing Yes No
- Wear a hearing aid Yes No
- Any other hearing or ear problems Yes No

13. Have you ever had a back injury? Yes No

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

- 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 you lean forward or backward at the waist Yes No
- Difficulty fully moving your head up and down 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 more than 25 lbs. Yes No
- Any other muscle or skeletal problems that interferes with using a respirator Yes No

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Name: _____ Date: _____

15. At work or home, have you ever been exposed to hazardous solvents, airborne chemicals (i.e. gases, fumes or dust) or have you come into skin contact with hazardous chemicals? Yes No

(If yes, please name the chemicals if you know them) _____

16. Have you ever worked with any of the materials, or under any of the conditions listed below?

- Asbestos Yes No
- Silica (i.e. in sandblasting) Yes No
- Tungsten/cobalt (i.e. grinding or welding this material) Yes No
- Beryllium Yes No
- Aluminum Yes No
- Coal Yes No
- Iron Yes No
- Tin Yes No
- Dusty environments Yes No
- Any other hazardous exposures Yes No

If yes, describe these exposures: _____

17. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier, are you taking any medications for other reasons? (including over the counter medications): _____

Due to the nature of Firefighting you will be placing yourself in situations that are uncommon to the general public. You will be trained and be required to use respirators in Escape, Emergency Rescue, and situations determined by incident. You will be wearing protective clothing and/or equipment (other than the respirator) while you are using the respirator. You will be working under hot conditions (temperatures above 77 Degrees F). You will be working in humid conditions. You will be working in hazardous conditions such as confined spaces involving life threatening toxins and smoke.

Please read and initial here: _____

Approved By Chief _____

cc: Deputy Chief _____

Date Forwarded to Membership Committee: _____

Date Probationary Checklist Completed: _____

Date Off Probation: _____