VOLUNTEER MEMBERSHIP APPLICATION
SOUTH BOSSIER PARISH FIRE DISTRICT TWO

LAST NAME: _____ FIRST NAME & MI: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ PAGER NUMBER: _____

SSN: _____ BIRTH DATE: _____ SEX: M F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: SINGLE: MARRIED: DIVORCED: SEPERATED: _____

E-MAIL ADDRESS: _____

DRIVERS LICENSE

PLEASE ATTACH A COPY OF YOUR CURRENT DRIVERS LICENSE

HAVE YOU BEEN ARRESTED/CHARGED FOR DWI/DUI? Y_____N_____

HAVE YOU HAD ANY TRAFFIC VIOLATIONS IN THE LAST 3 YEARS? Y_____N_____

HAVE YOU BEEN INVOLVED IN ANY MOTOR VEHICLE ACCIDENTS WITHIN THE LAST 3 YEARS? Y_____N_____

ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVER'S LICENSE? Y_____N_____

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION WHICH MAY AFFECT YOUR DRIVING ABILITY TO OPERATE A MOTOR VEHICLE? Y_____N_____

Please explain any yes answers above on the back of application.

FIREFIGHTING/MEDICAL CERTIFICATION

LEVEL OF EMS CERTIFICATION: EMR. EMT EMT-I EMT-P CPR

NATL. REG. # NATL. REG. and STATE EXP.

CPR TYPE (I.E. HEALTHCARE PROVIDER) CPR EXPIRATION DATE: _____

FIRST AID CARD: _____ EXPIRATION DATE: _____

HAVE YOU EVER BEEN A MEMBER OF ANOTHER FIRE DEPARMENT? _____

IF YES, NAME OF DEPARTMENT: _____ PHONE: _____

DO YOU HAVE ANY OF THE FOLLOWING FIRE CERTIFICATIONS?

FIREFIGHTER: I II HAZMAT: AWARENESS OPERATIONS TECH

FIRE SERVICE INSTRUCTOR: I II OTHER: _____

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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EDUCATION, EMPLOYER, SKILLS

HIGHEST GRADE COMPLETED: _____ COLLEGE DEGREE(S) _____

EMPLOYER: _____ EMP. PHONE: _____

VETERAN (Y or N): _____ BRANCH OF SERVICE: _____

SKILLS: _____

_____

REFERENCES

NAME ADDRESS PHONE

_____

_____

_____

ARREST/CONVICTIONS HISTORY

HAVE YOU BEEN ARRESTED/CHARGED FOR POSSESSION OR USE OF DRUGS? YES ____ NO _____

HAVE YOU BEEN ARRESTED/CHARGED FOR ANYTHING OTHER THAN A TRAFFIC VIOLATION? YES ____ NO _____

EXPLAIN ALL **YES** ANSWERS:

_____

_____

MEDICAL HISTORY

1. EYESIGHT:
   - A. HAVE YOU LOST USE OF EITHER EYE? R L
   - B. IS PERIPHERAL VISION RESTRICTED? Y N
   - C. ARE YOU COLOR BLIND? Y N
   - D. DO YOU HAVE, OR HAVE YOU EVER HAD CATARACTS? Y N
   - E. DO YOU WEAR GLASSES OR CONTACT LENS? Y N
   - F. DATE OF LAST EYE EXAMINATION _____

2. HEARING:
   - A. DO YOU HAVE DIFFICULTY HEARING NORMAL CONVERSATION? Y N
   - B. DO YOU USE HEARING AIDS? Y N

3. DIABETES:
   - A. HAVE EVER BEEN TREATED FOR DIABETES? Y N
   - B. WHAT TYPE OF DIABETES? TYPE–I or TYPE-II
   - C. WHAT MEDICATION AND METHOD OF ADMINISTRATION? _____

_____

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4. HEART:
   A. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE? Y N
   B. DESCRIBE CONDITION: _____
   _____
   C. DESCRIBE CURRENT MEDICATION AND DOSAGE: _____
   _____
   D. DO YOU HAVE A PACEMAKER? Y N
   E. DATE OF LAST TREATMENT OR CHECKUP. _____

5. EPILEPSY:
   A. HAVE YOU EVER BEEN TREATED FOR EPILEPSY? Y N
   B. IF "YES" WHEN WAS THE LAST SEIZURE? _____
   C. DESCRIBE CURRENT MEDICATION IF ANY. _____

6. BLOOD PRESSURE:
   A. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE? Y N
   B. IF "YES" WHEN WERE YOU TREATED? _____
   C. DESCRIBE CURRENT MEDICATION AND DOSAGE: _____
   _____

7. LIMBS:
   A. HAVE YOU LOST AN ARM, LEG, OR FINGER? Y N
   B. HAVE YOU LOST THE USE OF AN ARM, LEG OR FINGER? Y N
   C. DOES YOUR VEHICLE HAVE ANY SPECIAL DRIVING CONTROLS? Y N

8. MISCELLANEOUS:
   A. HAVE YOU EVER HAD ANY FAINTING SPELLS? Y N
   B. HAVE YOU EVER HAD OR BEEN TREATED FOR "LOSS OF EQUILIBRIUM"? Y N
   C. HAVE YOU EVER HAD OR BEEN TREATED FOR ALCOHOL OR DRUG ABUSE? Y N
   D. HAVE YOU EVER BEEN TREATED FOR MENTAL ILLNESS? Y N
   E. LIST ANY CURRENT MEDICATION BEING TAKEN.
   _____
   F. IF YOU ANSWERED YES TO ANY QUESTION IN ITEM 8, PLEASE DESCRIBE.
   _____
   _____

9. WHAT IS THE DATE OF YOUR LAST PHYSICAL EXAMINATION? _____
   ARE THERE ANY OTHER MEDICALS DISABILITIES OR PROBLEMS NOT COVERED IN PREVIOUS QUESTIONS, IF SO PLEASE LIST _____
   _____

10. FULL NAME. ADDRESS AND TELEPHONE NUMBER OF YOUR PERSONAL PHYSICIAN.
    NAME:_____ CITY:_____
    ADDRESS:_____ STATE/ZIP:_____

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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 SOUTH BOSSIER PARISH FIRE DISTRICT TWO, ANY SUCH INFORMATION.

I HEREBY AGREE TO INFORM THE FIRE DEPARTMENT OF ANY MOVING VIOLATION THAT I MAY RECEIVE AFTER TURNING IN THIS APPLICATION. I WILL NOTIFY THE DEPARTMENT WITHIN 72 HOURS OF RECEIVING THE VIOLATION. I UNDERSTAND THAT FAILURE TO DO SO WILL RESULT IN DISCIPLINARY ACTIONS, WHICH MAY INCLUDE TERMINATION.

I HEREBY AUTHORIZE SOUTH BOSSIER PARISH FIRE DISTRICT TWO TO INVESTIGATE ALL STATEMENTS IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION OR OMISSION OF FACTS CALLED FOR IS CAUSE FOR DISMISSAL OR DENIAL OF MEMBERSHIP.

I HEREBY AUTHORIZE SOUTH BOSSIER FIRE DISTRICT TWO TO OBTAIN COPIES OF MY TRAINING RECORDS FROM_____(Name of Institution)

SIGNATURE:_____ **DATE:**_____
SIGNATURE OF PERSON APPLYING

IF APPLICANT IS UNDER THE AGE OF EIGHTEEN (18), THEY MUST HAVE A PARENT OR GUARDIAN TO ALSO SIGN THE APPLICATION.

_____ _____
PARENT OF JUNIOR FIREFIGHTER **DATE**

FOR OFFICIAL USE ONLY

INTERVIEWED BY:_____ ACCEPTED: REJECTED:_____

REASON FOR REJECTION:_____

PROBATION BEGINS:_____ PROBATION ENDS:_____

HAS PICTURE BEEN TAKEN:_____ DRIVER CONSENT FORM SIGNED:_____

BENEFICIARY FORM COMPLETED:_____

AFTER PROBATION PERIOD ENDS:

STATUS OF APPLICANT:_____ DATE:_____

COMMENTS:_____

_____

SOUTH BOSSIER PARISH
FIRE DISTRICT TWO
3551 HWY 527
ELM GROVE, LA 71051
318-987-2555
FAX (318) 987-2554

911

Date:_____

South Bossier Parish Fire District Two
3551 Hwy 527
Elm Grove, LA 71051

Dear South Bossier Parish Fire District Two:

Consumer reports may be obtained as part of the South Bossier Parish Fire District Two evalutation of my volunteer application. The reports may include my driving record and assessment of my insurability under the Company's insurance coverages or other consumer reports. By signing this disclosure, I hereby aurhtorize South Bossier Parish Fire District Two to procure such reports and additional reports about me from time to time, as it deems appropriate, to evlauate my insurability or for other permissible purposes.

Sincerely,

_____
(sign your name)

_____
(print your name)

SOUTH BOSSIER PARISH
FIRE DISTRICT TWO
3551 HWY 527
ELM GROVE, LA 71051
318-987-2555
FAX (318) 987-2554

911

VFIS

Beneficiary Designation for Accident & Sickness Policy

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

Name of Organization_____State_____

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
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.

Examples Of The Most Frequently Used Beneficiary Designations

Individual (Always show relationship to the insured)	Show as Primary Beneficiary	Show as Contingent Beneficiary	Show as 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)
Insured's estate	Executors, Administrators, or Assigns of the Insured	(leave blank)	(leave blank)

SOUTH BOSSIER PARISH
FIRE DISTRICT TWO
3551 HWY 527
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OFFICE OF STATE FIRE MARSHAL, CODE ENFORCEMENT, AND BUILDING SAFETY

VOLUNTEER FIREMEN'S INSURANCE PROGRAM

BENEFICIARY DESIGNATION FORM

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 the Volunteer Firemen's Insurance Program 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
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.