

LaPlace Volunteer Fire Department

MEMBERSHIP APPLICATION

I _____ do hereby request membership in the LaPlace Volunteer Fire Department.

I understand that my membership is pending a six-month probationary period, during which time I will attend as many as possible, fire, drills, meetings, work details, and any other fire department functions for which I am called. Only upon my satisfactory completion of this probationary period will I become eligible for acceptance into this department.

Date: _____ Social Security #: _____

Full Name: _____ Home Phone #: _____

Address: _____ Alternate #: _____

Employed By: _____ Work Phone #: _____

Address: _____ City/Zip _____

Date of Birth: _____ Place: _____ Blood type: _____

Marital Status: *Single / Married / Divorce* Spouse Name: _____

Gender: Male / Female Height: _____ Weight: _____ Hair / Eye Color: _____

High School Attended: _____ Year Graduated: _____

Note: Must attach a copy of your High School Diploma College: _____

Allergies: _____ Medications: _____

Do you own a Vehicle: Yes / No Make: _____ Model: _____ Year: _____

Drivers License #: _____ Class: _____ Restrictions: _____

Prior Firefighting Experience: Yes / No Last Rank: _____

Department name: _____ Phone #: _____

Address: _____ City / State: _____

Copy of Training Records: Yes / No

I, the undersigned applicant for membership to the *LaPlace Volunteer Fire Department* do attest that all information contained herein is true and accurate and do hereby give permission for the Fire Chief to perform background checks.

Signature: _____ Date: _____

PERSONNEL INFORMATION

(PLEASE PRINT ALL INFORMATION)

BASIC INFORMATION

Employer: _____ Phone: _____

Address: _____

Occupation: _____

EMERGENCY CONTACT #1

Name: _____ Phone: _____

Address: _____ State: _____

Relationship: Mother / Father / Wife / Sister / Brother / Friend / Grandparent / Other _____
(Please Circle One)

EMERGENCY CONTACT #2

Name: _____ Phone: _____

Address: _____ State: _____

Relationship: Mother / Father / Wife / Sister / Brother / Friend / Grandparent / Other _____
(Please Circle One)

OTHER INFORMATION

1. Religion: *(Please Circle One)*

Catholic / Baptist / Episcopal / Evangelical / Jewish / Lutheran / Methodist / Mormon / Muslim
Pentecost / Presbyterian / Protestant / No Faith

2. Organ Donor: *(Please Circle One)* Yes / No

3. How did you hear about the LaPlace Volunteer Fire Department?

Beneficiary Designation for Accident & Sickness Policy

Complete this block 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 block 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 refer to back of form 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.



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. _____

NOTE: If any questions 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.	<input type="checkbox"/>	<input type="checkbox"/>
b. Is peripheral (side) vision restricted? b.	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you color blind? c.	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you have, or have you ever had, cataracts? d.	<input type="checkbox"/>	<input type="checkbox"/>
e. Are actual deficiencies corrected by glasses or contact lenses? e.	<input type="checkbox"/>	<input type="checkbox"/>
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."

Remarks:

Questions:

Remarks:

7. Blood Pressure:

Yes No

- 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

LaPlace Volunteer Fire Department

P.O. box 1009

LaPlace, Louisiana 70069-1009

E.L. Fagot
Central Fire Station
521 Hemlock Street

(985) 652-9445
Fax: (985) 652-2065

Check off list

Initial after you fill out each form or make copies of requested information.

- Fire Department Application _____
- Personnel Information _____
- Beneficiary Form _____
- St. John Parish Dept of Public Safety Picture ID form's _____
- Annual Medical Statement of Personnel _____
- Copy of High School Diploma _____
- Copy of Vehicle Insurance Card _____
- Copy of license _____