

# NOTTAWA/SHERMAN TOWNSHIP FIRE DEPARTMENT

6263 W. WEIDMAN RD., WEIDMAN, MICHIGAN. 48893 (517 644-3221)

## APPLICATION

ADOPTED 03/2000 REVISED 03/2000

POLICY # 26

*DO NOT FILL IN THE SHADED AREA*

*VOLUNTEER INFORMATION ONLY*

Date \_\_\_\_\_

Name \_\_\_\_\_ jr. / sr. D.O.B. \_\_\_\_\_ M [ ] F [ ] Blood type \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home ph # \_\_\_\_\_ Wk ph # \_\_\_\_\_ Other ph # \_\_\_\_\_

Present employer \_\_\_\_\_

Would your employer let you leave work for a serious fire? \_\_\_\_\_

SS # \_\_\_\_\_ DL # \_\_\_\_\_ Type of endorsement \_\_\_\_\_

DL exp Date \_\_\_\_\_ Current point \_\_\_\_\_ If yes, list driving violations for the last 5 years \_\_\_\_\_

Have you ever been charged with a felony Y [ ] N [ ]

If yes explain \_\_\_\_\_

Education circle highest level achieved 1 2 3 4 5 6 7 8 9 10 11 12 -college 1 2 3 4

Fire/medical training achieved \_\_\_\_\_

Marital status sgl [ ] married [ ] divorced [ ] Spouse's name \_\_\_\_\_ # of dependents \_\_\_\_\_

Are you taking any medication? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Are you currently under a doctor's care? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Is there any other medical information the fire dept. should know? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**OVER**

Are there any limitations that may prevent you from performing some of the assignments? Y [ ] N [ ]

(Climbing, carrying, breathing in a mask, seeing)

If yes, explain \_\_\_\_\_

Do you have any problems with a confined space, heights, or weight lifting restrictions? If yes please explain.

\_\_\_\_\_  
\_\_\_\_\_

*Joining will mean certain training will be required by Michigan laws, and department rules and regulations. You will have 24 mths from hire date to have the minimum of fire fighter 1 training.*

**I understand that if any information I have willfully falsified may be cause for my immediate dismissal.**

**I am aware and authorize a background check to be performed by the fire dept.**

X \_\_\_\_\_ date \_\_\_\_\_

Name of significant other \_\_\_\_\_ Emergency contact name \_\_\_\_\_ Ph# \_\_\_\_\_

**\*\* EMPLOYMENT CONTINGENT UPON MEDICALLY APPROVED PHYSICAL EXAMINATION \*\***

**OFFICE USE ONLY**

DATE APP. RECEIVED \_\_\_\_\_

DATE APP REVIEWED \_\_\_\_\_

APPROVED YES [ ] NO [ ]

REASONS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTES/RESTRICTIONS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DECISION BY \_\_\_\_\_

DATE \_\_\_\_\_