APPLICATION FOR MEMBERSHIP

COLTS NECK FIRE DEPARTMENT

P.O. Box 172 Colts Neck, NJ 07722

☐ **Fire Company # 1**
88 Route 537 West

☐ **Fire Company # 2**
50 Conover Road

Name (F,M,L): ____

Address: ____ Apt.: _______

City: ________________________________ State: ________ Zip: ___________

Date of Birth (MM/DD/YYYY): ________________ Age: ____ Social Security Number: ______________

Home Phone: __________________________ Work Phone: _____________________ Ext.: _______

Cell Phone: ____________________________ Cell Carrier: ________________________

Email Address: _________________________ 2nd email Address: _____________________________

Driver's License Number: _____________________ State: _______ Class: ________________

Is your driver's license suspended at this time: ☐Yes / ☐No

Has your driver's license ever been suspended? ☐Yes / ☐No

If yes, explain: ____

Next of Kin / Emergency Contact: ____

Relationship: _____________________________

Address: (Same as Above ☐) ____

Home Phone: (Same as Above ☐) ______________________________

Cell Phone: __________________________________

If still in High School, list school and current grade:

Have you ever been a fire fighter ? ☐Yes / ☐No If yes, complete the following:

If yes, NJ State ID # ____________________

Where and when:

Position(s) held and dates:

Course(s) taken: (attach copies of certificate(s))

Are you an EMT ? ☐Yes / ☐No If yes, NJ State ID # _________________

List all previous address(es) for the past 5 years. (attach additional sheet(s) if necessary)

Previous Address : ____

City: ___________________________ State: ________ Zip: _______________

Previous Address : ____

City: ___________________________ State: ________ Zip: _______________

Previous Address : ____

City: ___________________________ State: ________ Zip: _______________

Present Employer: ____

Address: ____

City: ___________________________ State: ________ Zip: ______________

Phone #: _________________________ Supervisor: _________________________________

Years Employed ?: ______________________________

List all previous employer(s) for the past 5 years. (attach additional sheet(s) if necessary)

Previous Employer: ____

Address: ____

City: _________________________________ State: ___________ Zip: __________________

Dates of Employment: From __________________________ to _________________________________

Position Held: ____

Reason for Leaving: ____

Previous Employer: ____

Address: ____

City: _________________________________ State: ___________ Zip: __________________

Dates of Employment: From __________________________ to _________________________________

Position Held: ____

Reason for Leaving: ____

Previous Employer: ____

Address: ____

City: _________________________________ State: ___________ Zip: __________________

Dates of Employment: From __________________________ to _________________________________

Position Held: ____

Reason for Leaving: ____

Provide the names and contact phone number for 3 references (not relatives)

Reference Name 1: ______________________________________ Phone #: _________________________

Reference Name 2: ______________________________________ Phone #: _________________________

Reference Name 3: ______________________________________ Phone #: _________________________

Provide the name and location of any high school, college and/or trade school you have attended. List dates, course of study and any degree/certificate earned.

Are you a veteran of the Armed Forces of the United States ? ☐Yes / ☐No

If yes, note branch and dates of service:

Have you been hospitalized for any reason within the past 5 years ? ☐Yes / ☐No

If yes, list the date(s), hospital, nature of condition, illness or injury that required hospitalization.

Have you ever been convicted or pled guilty to a crime or disorderly persons offense in the past 10 years, which has not been annulled, expunged or sealed by the court ? ☐Yes / ☐No

If yes, explain:

Authorization to release information

To whom it may concern:

I hereby request and authorize you to furnish the Colts Neck Fire Department, Township of Colts Neck with any and all information they may request concerning my work record, educational history, military record, criminal record, general reputation and past or present medical condition. This authorization is specifically intended to include any and all information of a confidential or privileged nature as well as photocopies of such documents if requested. The information will only be used for the purpose of determining my eligibility for membership within the Colts Neck Fire Department.

I hereby release you and your organization from any liability which may or could result from furnishing the information requested above or from any subsequent use of such information in determining my qualifications to serve as an emergency response person.

Signed: ____

Print Name: _______________________________________

Sworn and subscribed to, before me
This _______ day of ___________,
20____.

Notary public of New Jersey ____________________________________

PHYSICAL EXAMINATION

Colts Neck Volunteer Fire Department

Date of Birth	Sex

Name	Marital Status

Address	Social Security Number

Personal Physician (Name & Address)	Phone Number

Family History

Has any of your family ever had:	Cancer	Diabetes	Heart Disease	Tuberculosis
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Occupational

Current and previous occupations – Type and duration
Has work ever been refused or restricted for health reasons ? ☐ Yes ☐ No

Military

Branch	Length of Service	Medical Discharge	Medical Rejection
		☐ Yes ☐ No	☐ Yes ☐ No

Your History

Have you ever had or do you now have:

Cancer	☐ Yes	☐ No	Jaundice or Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Headaches, Frequent or Severe	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Fainting, Dizziness	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Allergy or Drug Reaction	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Skin Rash, Chronic or Severe	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No	Back Pain or Injury	☐ Yes	☐ No

Clinical Evaluation

Height	Weight	Blood Pressure	Pulse	Respiration

Vision	Uncorrected		Corrected		Color	**Hearing**	
	L	R	L	R			
Distant						R	
Near						L	

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
1. Skin			8. Heart			15. Spine		
2. Head – Neck			9. Lungs			16. Neurological		
3. Eyes			10. Abdomen			17. Lymph Glands		
4. Ears			11. Hernia			18.		
5. Mouth – Teeth			12. Extremities			19.		
6. Nose - Throat			13. Varicosities			20.		
7. Chest			14. Joints - Muscles			21.		

Details of Abnormal Findings

Recommended: Yes / No

Has the above named individual been advised of the findings of this examination ? Yes / No

Physician’s Stamp & Signature