Argyle Volunteer Fire Department

Jonathan Day, Chief
P.O. Box 61
Argyle, FL, 32422

Membership Application

Thank you for your interest in joining our department. Please be advised that information provided in this document is completely confidential and no one will have access other than you and Chief Day. We ask that you complete this packet as soon as possible, as there is a time-sensitive process.

Once completed, you may submit this application three ways,

You may mail the application to:
Argyle Volunteer Fire Department
P.O. Box 61
Argyle, Florida, 32422

- or -

You may hand deliver to Chief Day
Station 91
67 Fire Department Ave
Argyle, FL, 32422

- or -

You may email to:
chiefjday@yahoo.com

Please feel free to contact us in any way if you need help completing this application.

Argyle Volunteer Fire Department Office
67 Fire Department Ave
Argyle, FL, 32422
Phone: (850) 892-4702
Fax: (850) 892-4703
Email: chiefjday@yahoo.com

Argyle Volunteer Fire Department
Emergency Contact

Personal Information

Last Name _____ First Name _____ M.I. _____
DOB _____ Sex _____ SS # _____ Unit # _____
Address (line 1) _____
Address (line 2) _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____

Emergency Contact _____ Phone _____

Occupation _____ Employer _____ Phone _____
Address _____
City _____ State _____ Zip _____

Medical Information

Primary Care Physician _____ Phone _____
Address _____
City _____ State _____ Zip _____

Medications ***please list all daily medications***

_____
_____
_____
_____
_____
_____
_____

Allergies ***please list medication, food, and seasonal allergies***

_____
_____
_____
_____
_____
_____
_____

Past Medical History ***please list any pertinent past or present medical issues***

_____
_____
_____
_____

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 Argyle Volunteer Fire Department any such information."

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

_____ _____
Signature Date

Argyle Volunteer Fire Department

Jonathan Day, Chief
P.O. Box 61
Argyle, FL, 32422

RE: Changes to Personnel File
Please report any changes to your personal file and mail it to:

Chief Day
AVFD P.O. Box 61
Argyle, Florida, 32422

-or-

Call the office at (850) 892-4702. If you do not receive an answer, please leave a message. If you need a copy made, please call or come by the office. Any changes made can be left in the "INBOX" at my desk.

Changes include:

*Address
*Phone number
*Marital status
* Employment status with phone number
*Emergency contact with phone number
*Driver's license
*Any medical reports needed at AVFD
*Shot record
*Beneficiary
*New awards or certificates.

Please provide three (3) personal references in the area provided below.

Name_____ Phone: _____Time Known: _____

Name_____ Phone: _____Time Known: _____

Name_____ Phone: _____Time Known: _____

Argyle Volunteer Fire Department

Jonathan Day, Chief
P.O. Box 61
Argyle, FL, 32422

To: Applicant for Argyle Volunteer Fire Department
From: Chief Jonathon Day
Re: Membership in Another Volunteer Fire Department

I , _____

A. Am a member of Argyle Volunteer Fire Department

B. Would like to become a member of Argyle Volunteer Fire Department

C. Have you ever been a member of another volunteer fire department?

if yes, where and when_____

D. What was your rank at your previous department?_____

E. What position are you applying for?

F. While applying for membership to AVFD, I understand that I will go through a probationary period with training until released by the Argyle Board of Directors. I understand that more intense medical questions will be asked upon evaluation for acceptance.

G. How would you describe your personal health?

**Health questions are asked for the safety of you, the applicant.

Argyle Volunteer Fire Department

Jonathan Day, Chief
P.O. Box 61
Argyle, FL, 32422

I ,_____, hereby apply for membership into Argyle Volunteer Fire Department.

Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

DOB _____DL# _____State_____ Expires: _____

Employer: _____ Phone: _____

Contact Name: _____Email: _____

Have you even been convicted of a felony or misdemeanor within the past 7 years?

Will you use and wear the personal protection equipment provided by the AVFD?

Are you a member of a volunteer fire department currently?

Are you of good moral character?

Will you participate actively in training, firefighting, cleaning, testing etc. to the best of your ability?

Do you have any medical problems that will restrict you in performing firefighter functions in a stressful situation?

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. _____

REMARKS: If any question 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: _____

	Yes	No
2. Eyesight:		
a. Have you lost use of either eye? ☐ R ☐ L	☐	☐
b. Is peripheral (side) vision restricted?	☐	☐
c. Are you color blind?	☐	☐
d. Do you have, or have you ever had, cataracts?	☐	☐
e. Are actual deficiencies corrected by glasses or contact lenses?	☐	☐
f. Date of last eye examination: _____		
3. Hearing:		
a. Do you have difficulty hearing normal conversation level?	☐	☐
b. Do you use a hearing aid?	☐	☐
4. Diabetes:		
a. Have you ever been treated for diabetes?	☐	☐
b. Describe current medication and dosage, if any, and method of administration under "remarks."		
c. Date of latest blood sugar test: _____		
5. Heart:		
a. Have you ever been treated for heart disease?	☐	☐
b. Describe condition: _____		
c. Describe current medication and dosage, if any, under "remarks."		
d. Do you have a pacemaker?	☐	☐
e. Date of last treatment or check-up: _____		
6. Epilepsy:		
a. Have you ever been treated for epilepsy?	☐	☐
b. If "Yes," when was your last seizure? _____		
c. Describe current medication and dosage, if any, under "remarks."		

Questions:

REMARKS:

	Yes	No
7. Blood Pressure:		
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 _____ Argyle Volunteer Fire 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**

Beneficiary Designation for Accident & Sickness Policy

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

Name of Organization Argyle Volunteer Fire 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 (Please see below 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.

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All applicants will be required to have a background check and an initial drug screening completed, with the possibility of a random drug screening if accepted into Argyle Fire Department. These are done at the expense of the fire department.

By signing at the bottom of this page, you are agreeing that the information provided is correct to the best of your knowledge on above application and specifications assigned by the Argyle Fire Department.

Signature: _____ Date: _____

Approved By: _____ Date: _____