EAST MAINE FIRE COMPANY, INC.

847 East Maine Road
Johnson City, NY 13790
http://home.stny.rr.com/emfc56

Telephone (607) 797 - 0685
Fax (607) 797- 0685
email: chief56@stny.rr.com

MEMBERSHIP APPLICATION

NAME: _____ HOME PHONE: (____) _____
ADDRESS: _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: ____/____/____
SINGLE: ____ MARRIED: ____ IF MARRIED, SPOUSE'S NAME: _____
PLACE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____ STATE:_____ CLASS: _____
RESTRICTIONS: _____
LIMITATIONS: _____
STATUS:_____

EMPLOYER/SCHOOL: _____
OCCUPATION: _____
ADDRESS: _____
WORK PHONE: (____) _____ EXTENSION: _____ SHIFT: _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES: _____ NO: _____
IF YES PLEASE EXPLAIN, INCLUDE DATES: _____
_____
_____

PLEASE LIST ALL EXPERIENCE OR TRAINING IN FIREFIGHTING YOU HAVE PREVIOUSLY HAD, PLEASE INDICATE WHERE AND WHEN (USE ADDITIONAL SHEETS IF NECESSARY):

_____
_____
_____

PLEASE COMPLETE THE MEDICAL EMERGENCY INFORMATION ON THE REVERSE SIDE

By signing below you authorize the East Maine Fire Company, Inc to perform all background checks it deems necessary to properly evaluate your application.

APPLICANTS SIGNATURE: _____

PARENT'S SIGNATURE: _____
(IF APPLICANT IS UNDER 18 YEARS OF AGE) DATE: _____

NOTICE: FILLING OUT OF THIS APPLICATION ***DOES NOT*** GUARANTEE THAT THE APPLICANT WILL BE ACCEPTED INTO THE FIRE COMPANY. IF ACCEPTED, YOU MUST ABIDE BY ALL THE RULES AND PRACTICES SET FORTH BY THE FIRE COMPANY/CORPORATION AND ITS OFFICERS.

FIRE COMPANY USE ONLY (DO NOT MARK BELOW THIS LINE)
DATE OF FIRST READING: _____ DATE OF SECOND READING: _____
DATE OF ACCEPTANCE INTO EAST MAINE FIRE COMPANY, INC.: _____

EAST MAINE FIRE COMPANY, INC
EMERGENCY MEDICAL INFORMATION

PLEASE NOTE THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND WILL ONLY BE RELEASED TO HOSPITAL/EMS PERSONNEL IF YOU ARE INJURED.

PHYSICIAN _____DENTIST_____

HEALTH INSURANCE CARRIER_____

HOSPITAL PREFERENCE_____

HEIGHT: _____ WEIGHT: _____

EYE COLOR: _____ HAIR COLOR: _____

DO YOU WEAR GLASSES/CONTACTS: _____ DO YOU SMOKE: _____

DO YOU WEAR A MEDIC ALERT BRACELET/NECKLACE:_____

IF YES WHAT FOR:

_____

BLOOD TYPE: _____ ARE YOU WILLING TO DONATE BLOOD: _____

ARE YOU AN ORGAN DONOR: _____ IS YOU LICENSE PROPERLY FILLED OUT: _____

DATE OF LAST TETANUS SHOT/BOOSTER: _____

DO YOU HAVE ANY PAST MEDICAL HISTORY AND OR DISABILITIES (I.E. DIABETES, HEART ATTACK, ETC):

_____

_____

_____

DO YOU HAVE ANY KNOWN ALLERGIES:

_____

_____

_____

ARE YOU CURRENTLY ON ANY MEDICATIONS (please list medications):

_____

PERSON TO CONTACT IF YOU HAVE AN ACCIDENT:

_____

ADDRESS: _____

PHONE NUMBER: (____) _____ RELATIONSHIP: _____

RELIGION: _____

You will be required to take and pass a physical performed by the Broome County Health Department in order to be covered by workers compensation insurance.

Yearly/Bi-annual physicals are offered free of charge to department members through Lourdes Occupational Health.