Westerly Fire Department

Headquarters
7 Union Street • Westerly, Rhode Island 02891
401-596-0402 • Fax 401-596-3350

APPLICATION FOR MEMBERSHIP

PLEASE CHECK ONE OF THE FOLLOWING:
ALERT HOOK & LADDER COMPANY ☐ CYCLONE STEAM FIRE ENGINE CO. #2 ☐
RHODE ISLAND STEAM FIRE ENGINE CO. #1 ☐ FIRE POLICE ☐

NAME_____ DATE_____

ADDRESS_____

FORMER ADDRESS_____

EMPLOYMENT/OCCUPATION_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

TELEPHONE #_____ CARRIER_____ EMAIL ADDRESS_____

REFERENCES:

NAME_____

ADDRESS_____

TELEPHONE #_____ EMAIL ADDRESS_____

NAME_____

ADDRESS_____

TELEPHONE #_____ EMAIL ADDRESS_____

NAME_____

ADDRESS_____

TELEPHONE #_____ EMAIL ADDRESS_____

PAST/PRESENT MEMBER ORGANIZATIONS-

_____ FROM_____ TO_____

_____ FROM_____ TO_____

_____ FROM_____ TO_____

_____ FROM_____ TO_____

Westerly Police Dept.
60 Airport Road
Westerly, RI 02891
401-596-2022
401-596-7501 (Fax)

I hereby authorize the Westerly Police Department to release any personal criminal information or data from this department or from the State of Rhode Island with regard to myself. This record must be released to me or to the company listed below with whom I am seeking employment.

_____
Name of Company

TODAY'S DATE: _____

Criminal Record Check Release Form

Signature: _____
Please print below information:

Name: _____

Maiden name (s) / Alias: _____

Date of Birth: _____ S.S. # _____

Telephone # _____

Street Address: (No PO Boxes) _____

Town: _____ State _____ Zip _____

Previous Residence: _____

DO NOT WRITE BELOW THIS LINE

Official Use Only

Criminal Record Information:

Town of Westerly	**Record**	**YES**	**NO**	
State of Rhode Island BCI	**Record**	**YES**	**NO**	
Are records attached?		**YES**	**NO**	**See below**

Explanation of Police Record below this line

_____
_____
_____
_____

_____ _____
Clerk / Officer Signature **Date**

WESTERLY FIRE DEPARTMENT PHYSICAL FORM
7 UNION ST. WESTERLY RI 02891 401-596-0402

Date:_____

Name:_____

Date of Birth:_____

Following a complete physical the above individual is authorized for: (please check only one)

___Interior structural firefighting

INTERIOR STRUCTURAL FIREFIGHTING DUTIES

Includes all the essential job functions in "FIREFIGHTING DUTIES OTHER THAN INTERIOR STRUCTURAL" plus the following:

- Wears self-contained breathing apparatus (SCBA) and full protective gear (approx. 70lbs total) while performing arduous work in noxious and/or smoke-filled environments while climbing multiple flights of stairs
- Operates firefighting equipment in areas compromised by fire, confined spaces, and high places such as ladders and roofs
- Carries and moves heavy equipment and/or objects necessary to accomplish fire extinguishment or rescue (HEAVY CARDIAC DEMAND)
- Performs immediate actions under life threatening conditions which requires emotional and physical stability under stress
- Tolerates extreme fluctuations in temperature. Must perform physically demanding tasks in extreme heat (over 400°F) with humidity up to 100%
- Perform rescue of child or adult victims, or other firefighter, as necessary by dragging, lifting, and/or carrying, with or without assistance, in dangerous situations.

___Firefighting duties other than interior structural

FIREFIGHTING DUTIES OTHER THAN INTERIOR STRUCTURAL

- Wears full protective firefighting gear (approx. 35-40lbs) while working in outdoor environment performing moderate and heavy physical activities for prolonged periods.
- Directs high pressure water streams; raises, climbs and works from ladders (10-100ft)
- Lifting and carrying up to 50lbs. alone, carrying up to 100lbs. with one other person
- Pushing and/or pulling up to 150lbs. alone
- Balancing, stooping, kneeling, crouching, crawling, and reaching overhead, at times for prolonged periods
- Drive and operate fire apparatus (with or without protective gear – situation dictates)

___Not fit for any on scene firefighting duties, ONLY off scene support

Physician signature_____Address_____

Physician name (print please)_____Telephone #_____

Annual Medical Statement of Personnel

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. Member participation in completing this form is not mandatory but is encouraged on an annual basis for all drivers of emergency vehicles as well as other employees.

Member Name: _____ Today's Date: _____

Address: _____ Birth Date: _____

City & State: _____ Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Member ID#: _____

Instructions: Check "Yes" or "No" to the following questions. If any question is answered "Yes," please provide further details in the "remarks" section. Please provide dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc. where pertinent.

		YES	NO	REMARKS
1.	**EYESIGHT**			
a.	Have you lost use of either eye?	☐	☐	
b.	Is peripheral (side) vision restricted?	☐	☐	
c.	Is color perception impaired?	☐	☐	
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:			
2.	**HEARING**			
a.	Do you have difficulty hearing at a normal conversation level?	☐	☐	
b.	Do you use a hearing aid?	☐	☐	

DISCLAIMER: This is a sample guideline furnished to you by VFIS. Your organization should review this guideline and make the necessary modifications to meet your organization's needs. The intent of this guideline is to assist you in reducing exposure to the risk of injury, harm, or damage to personnel, property, and the general public. For additional information on this topic, contact your VFIS Risk Control Representative at (800) 233-1957.

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		YES	NO	REMARKS
3.	**DIABETES**			
a.	Have you ever been treated for Diabetes?	☐	☐	
b.	Describe current medication and dosage, if any, and method of administration:			
c.	Date of latest blood sugar test:			
4.	**HEART**			
a.	Have you ever been treated for Heart Disease?	☐	☐	
b.	Describe condition:			
c.	Describe current medication and dosage, if any:			
d.	Do you have a pacemaker?	☐	☐	
e.	Date of last treatment or check-up:			
5.	**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:			
6.	**LUNGS**			
a.	Have you ever been treated for Asthma or COPD?	☐	☐	
b.	Describe condition:			
c.	Describe current medication and dosage, if any:			
d.	Date of last treatment or check-up:			
7.	BLOOD PRESSURE			
a.	Have you ever been treated for High Blood Pressure?	☐	☐	
b.	If "Yes," when were you treated?			

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		YES	NO	REMARKS
c.	What was your last reading?			
d.	Describe current medication and dosage, if any:			
8.	**LIMBS**			
a.	Have you lost an arm or leg?	☐	☐	
b.	Have you lost the use of an arm or leg?	☐	☐	
c.	Does vehicle have special controls?	☐	☐	
d.	If "Yes," to any of the above, describe:			
9.	**MISCELLANEOUS**			
a.	Have you ever had, or been treated for, Convulsions?	☐	☐	
b.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
c.	Have you ever had any Fainting Spells?	☐	☐	
d.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
e.	Have you ever had, or been treated for, Loss of Equilibrium?	☐	☐	
f.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
g.	Have you ever been treated for Alcohol or Drug Abuse?	☐	☐	
h.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
i.	Have you ever been treated for Mental Illness?	☐	☐	
j.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			

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		YES	NO	REMARKS
10.	What was 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 that may affect your ability to operate a motor vehicle?	☐	☐	
13.	When and for what purpose did you last consult a doctor?			

The answers to the above are complete, accurate and true to the best of my knowledge.

Member's Signature _____ Date _____

Consent to Participate

I hereby acknowledge that this form is voluntary and that all information provided by me to the agency will be utilized solely to alert the agency of any health conditions that may affect my ability to perform my job duties. I understand that this information is not required but may help the agency make determinations on any work restrictions that will help to better support the agency's mission. I further acknowledge that the information provided on this form will be held confidential and will not be shared with any party other than agency management.

Member's Signature _____ Date _____

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QUALIFIED RETIREMENT PLAN ENROLLMENT FORM

GENERAL INFORMATION

Westerly Fire District Pension Plan

Plan Name | *Participant Name*

Date of Birth (Mo., Day, Year) | *Date of Hire (Mo., Day, Year)* | *Social Security Number* | *Department/Division (if applicable)*

N/A

SALARY DEFERRAL AND ROLLOVER CONTRIBUTION AUTHORIZATION

- ☐ I hereby request that my compensation be reduced by _____ % (not to exceed current plan and/or IRS limitations), with the amount of such salary reduction to be applied as a contribution to the Plan.
- ☐ I decline to have my compensation reduced at this time.
- ☐ I hereby elect to invest my Rollover Contributions to the Plan at this time.

BENEFICIARY DESIGNATION (Complete Beneficiary Designation Section only if you are a new participant or if you wish to change your beneficiary)

☐ **Married Participant** I understand that I must elect my spouse as sole Primary Beneficiary under this Plan, unless he/she consents in writing to my naming another Primary Beneficiary. If my Plan is subject to Joint and Survivor Annuity benefit payment rules, then when I am age 35, I will have the right to designate a beneficiary of my choosing, provided my spouse consents. Further, when I am age 32, the Plan Administrator will provide me with a detailed explanation of my rights regarding my death benefit. I will therefore inform the Plan Administrator when I turn age 32, and if there is a change in my marital status.

☐ **Unmarried Participant** I understand that the following designation becomes null and void in the event of my marriage. I will promptly inform the Plan Administrator of any change in my marital status.

I understand that if I outlive my Primary beneficiary, benefits will be paid to my estate on my death, unless I designate a Contingent Beneficiary(ies).

PRIMARY BENEFICIARY

Name | *Date of Birth* | *Relationship* | *% Share*

Address | *City* | *State* | *Zip Code*

PRIMARY BENEFICIARY

Name | *Date of Birth* | *Relationship* | *% Share*

Address | *City* | *State* | *Zip Code*

CONTINGENT BENEFICIARY

Name | *Date of Birth* | *Relationship* | *% Share*

Address | *City* | *State* | *Zip Code*

CONTINGENT BENEFICIARY

Name | *Date of Birth* | *Relationship* | *% Share*

Address | *City* | *State* | *Zip Code*

PARTICIPANT SIGNATURE

X _____ / / *Date*