Name: ____________________________ Monitor #:_____________

Jarrettsville Volunteer Fire Company

Membership Application

Jarrettsville Volunteer Fire Company, Inc .

• FIRE SUPPRESSION • AUXILIARY • EMERGENCY MEDICAL SERVICES •

Dear Perspective Member,

On behalf of the Board of Directors, Officers, and Members of the Jarrettsville Volunteer Fire Company, we would like to extend our sincere appreciation and welcome you in expressing interest in becoming a member of the company. The Jarrettsville Volunteer Fire Company has been a proud tradition protecting the community since 1929.

Enclosed in this packet is an application that must be filled out in it's entirety along with the physical form and the background check form. The packet may be returned any Monday night after 7 p.m. to the Jarrettsville Volunteer Fire Company House # 1 located at 3825 Federal Hill Road (Rt. 165) in Jarrettsville. If all of the bay doors are closed, in the front of the building there is a single door to the right of the bay doors that has a doorbell.

A $2.00 (Two Dollar) application fee is due when your application is turned in, prior to the application process being started. This can be paid in either cash or check made payable to Jarrettsville Volunteer Fire Company.

At the time that you are voted in as a member of the company, you will be placed on a 6-month probationary status. After 3 months of probation, all probationary members will be evaluated by the Recruitment and Retention Committee for activities (i.e., number of calls, cleanups, classes, drills, meetings, etc). If the committee feels your activities are low, you will be contacted by a member of the committee to discuss your performance.

Once again, on behalf of Members of the Jarrettsville Volunteer Fire Company, we would like to welcome you into the Fire & EMS Service in Harford County. If you have any questions, please do not hesitate to ask.

Sincerely,

Jarrettsville Volunteer Fire Company
Recruitment & Retention Committee

P.O. BOX 7. 3825 FEDERAL HILL ROAD. JARRETTSVILLE. MARYLAND 21084

Membership Application **Monitor #:_________**

Name________________________,______________________,______________________
(Last) (First) (Middle)

Street Address____ Apt. #___________

City__________________________ State_______________ Zip Code_______________

Date of Birth______/______/______ Social Security #________/________/_________

Sex (Male), (Female) Drivers License #________________________ State______

Home Phone # (____)_____-_______ Work Phone # (____)_____-_______

Emergency Contact____________________________ ______________________
(Name) (Phone)

Medical History____

____

Medications____

Allergies____

Have you ever been convicted of a crime? Yes ( ) No ( )

If yes, Explain____

Interested In: Fire ( ) EMS ( ) Both ( ) Other ( )

****

Have you ever been a member of this or any other fire department? If so please fill out the section in detail.

Company Name__________________________ Phone Number (____)_____-_______

Address____
(Street) (City) (State) (Zip)

Date Left________________ Reason____

List any previous training____

____

Two Business or Professional references are required (over the age of 25) - List them below:

(1)

Name______________________________________ Phone Number (____)_____-_______

Address____
(Street) (City) (State) (Zip)

How long known?___________ Type of relationship______________________________

(2)

Name______________________________________ Phone Number (____)_____-_______

Address____
(Street) (City) (State) (Zip)

How long known?___________ Type of relationship______________________________

****

Present Employer

Company Name___________________________ Phone Number (____)_____-_______

Address____
(Street) (City) (State) (Zip)

Position____ Date Hired___________________

Supervisor____

If still in High School, give name of school and two points of contact. (i.e. Teacher, Guidance Counselor)

School Name_____________________________ Phone Number (____)_____-_______

Name_____________________________________ Occupation________________________

Name_____________________________________ Occupation________________________

****

It is understood and agreed that any misrepresentation on this application will be sufficient cause for cancellation of the application or termination from the company, if I have been accepted as a member. I also agree to abide by the Constitution, By-Laws and S.O.G.'s of the Jarrettsville Volunteer Fire Company. It is understood that the Jarrettsville Volunteer Fire Company will verify all information on this application. They will do so with my consent, and submit their findings to the Jarrettsville Volunteer Fire Company Membership.

Applicant's Signature____ Date_____________

****

DO NOT WRITE IN THIS SECTION

(For Fire Company use only)

Date application received ______/______/______

Date dues received ______/______/______

Interviewed by______________________________

Date voted on for probationary status______/______/______ Accepted (YES) (NO)

Date voted on for regular membership______/______/______ Accepted (YES) (NO)

Request for 6 month extension ______/______/______

Resignation date ______/______/______ Reason_______________________________

****

Parental Consent For Minors

I hereby give my son/daughter permission to join the Jarrettsville Volunteer Fire Company. I understand that they will need to abide by the rules and regulations set forth by the Jarrettsville Volunteer Fire Company.

Name of Applicant________________________________ Date______/______/______

Parent/Guardian Signature____

Any further questions contact Ruth Hoskins at (410)638-3406

Jarrettsville Volunteer Fire Company, Inc .

• FIRE SUPPRESSION • AUXILIARY • EMERGENCY MEDICAL SERVICES •

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. ______________

1. Birth Date: Month: __________ Day: ______ Year: ______

2. Eyesight: Yes No

a. Have you lost use of either eye? ________ R ________ L.........a. ☐ ☐

b. Is peripheral (side) vision restricted?.............b. ☐ ☐

c. Are you color blind? ....c. ☐ ☐

d. Do you have, or have you ever had, cataracts? ....d. ☐ ☐

e. Are actual deficiencies corrected by glasses or contact lenses?...e. ☐ ☐

f. Date of last eye examination:.............f. ________

3. Hearing:

a. Do you have difficulty hearing normal conversation level?...........a. ☐ ☐

b. Do you use a hearing aid? ....b. ☐ ☐

4. Diabetes:

a. Have you ever been treated for diabetes? ....a. ☐ ☐

b. Describe current medication and dosage, if any, and method of administration under "remarks."

c. Date of latest blood sugar test: ....c. ________

5. Heart:

a. Have you ever been treated for heart disease? ....a. ☐ ☐

b. Describe condition:.............b. ________

c. Describe current medication and dosage, if any, under "remarks."

d. Do you have a pacemaker? ....d. ☐ ☐

e. Date of last treatment or check-up: ....e. ________

6. Epilepsy:

a. Have you ever been treated for epilepsy?.............a. ☐ ☐

b. If "Yes," when was your last seizure?.............b. ________

c. Describe current medication and dosage, if any, under "remarks."

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.

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 __________ ____ 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**

PROCEDURES:	**ENROLLMENT IN THE LENGTH OF SERVICE AWARD PROGRAM (LOSAP)**
SOURCE(S):	**LOSAP LIAISON**
CONTACT(S):	**LOSAP LIAISON** **PAYROLL SUPERVISOR**
DISTRIBUTION:	**LOSAP LIAISON** **PAYROLLSUPERVISOR**
TIMEFRAME:	**30 DAYS OF START DATE**
RETENTION AND STORAGE:	N/A

PROCEDURES AND SAMPLES:

d.

1. FireFighters and Ambulance Personnel volunteer as qualified active members of the Harford County Volunteer Fire Department/Companies or Ambulance Corp. and/or any Volunteer Fire Company receiving contributions from Harford County.

2. The volunteer will fill out the Volunteer Firemen Pension LOSAP Enrollment Form (see attached), W-9 Form, and with a copy of their driver's license should be forwarded to the LOSAP Liaison.

3. The LOSAP Liaison will forward the Enrollment Form, W-9 Form and the copy of their driver’s license to Harford County Treasury Department (Actuarial Accountant) within 30 days after the date of enrollment.

4. The Actuarial Accountant will date stamp the LOSAP Enrollment Form when received.

5. The Actuarial Accountant will review the form for completeness.

    a. Non-completed forms will be returned to the LOSAP Liaison within 10 days of stamp receipt. The LOSAP Liaison will need to complete the form and return within 30 days of receipt.

6. The Actuarial Accountant will create a file for the volunteer which will include the Enrollment Form, W-9 Form, a copy of their driver's license and any other information pertaining to the individual.

7. The Actuarial Accountant will add the volunteer to the Firemen and Ambulance Personnel database.

VOLUNTEER FIREMEN PENSION LENGTH OF SERVICE AWARD PROGRAM (LOSAP) ENROLLMENT FORM

FIRE COMPANY: ____

MEMBER NAME: ____

MEMBER ADDRESS: ____

____

SOCIAL SECURITY #: ____

DATE OF BIRTH: ____

DATE OF ENROLLMENT: ____

MARITAL STATUS: ____

SPOUSE'S NAME: ____

SPOUSE'S SOCIAL SECURITY #: ____

____

Signature of Authorized Personnel
LOSAP Liaison

Form must be submitted to Harford County Treasury Department, Payroll, no later than 30 days after the volunteered date of enrollment

Harford County Government
Treasury Department, Payroll
45 South Main Street
Bel Air, MD 21014

410-638-3379

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,