EAST ROANE COUNTY VOLUNTEER FIRE DEPARTMENT

853 New Midway Rd Kingston, TN 37763
Phone: 865-376-4170

Please email application to info@eastroanefire.org or Mail to: P.O. Box 283, Kingston, TN 37763

MEMBERSHIP APPLICATION

Name:		
Date of birth:	SSN:	
Current address:		
City:	State:	ZIP Code:
Home Phone:	Mobile #:	Blood Type:
Drivers' License #:	Class:	Expiration Date:
Email Address:		
Positions *(Circle all that apply)* : Firefighter EMR Auxiliary Explorer		
EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
SPOUSE INFORMATION		
Name:		Phone:
Have you ever been a member of another Fire Department? Yes ☐ No ☐		
If Yes , Where :		
Do you have any special training in this field? Yes ☐ No ☐		
If Yes, Please Specify:		
Are you willing to adhere to department policies as prescribed by our By-Laws, SOP and SOG's? Yes ☐ No ☐		
Why Do you want to be a Firefighter, EMR, Auxiliary or Explorer member?		
REFERENCES		
Name	Address	Phone
SIGNATURES		
I authorize the verification of the information provided on this form for membership.		
Signature of applicant:		Date:
Signature of Guardian *(only if for a Explorer membership):*		Date:

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Employee Workers Compensation Consent Form

- I have read the Roane County WORKERS COMPENSATION BENEFITS AND PROCEDURES HANDBOOK.
- I agree to follow all safety procedures and regulations that relate to the performance of my employment with Roane County.
- I understand that I must report all on the job injuries to my supervisor within 72 hours.
- I understand that to be reimbursed for Medical expenses incurred for medical treatment of an on the job injury, I must seek medical assistance from a member of the Roane County Panel of Physicians.
- I understand that all medical information related to my injury will be reported to the Roane County Workers Compensation office and subject to review by the Risk Management Committee / Accident Review Board of the Roane County Commission (Resolution 2344, April 13, 1992).

Signed:
Date:
Date placed in member's file:

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Member Confidentiality Agreement

As a member of the East Roane County Volunteer Fire Department (ERCVFD), I may have the opportunity to observe members of the ERCVFD in the performance of their official duties. During these activities, I understand that I must adhere to strict confidentiality requirements in order to protect the privacy of patients under the care of EMS personnel and victims of fire. This confidentiality includes discussing or sharing the responses or any electronic media used to alert a member with parents, peers, or news media that are not members of ERCVFD.

I understand the potential exists for me to observe emergency calls involving persons of any age and that I may encounter classmates and other people I know. I understand that I will be immediately dismissed from the ERCVFD if this policy is violated. I further understand that I may at any time discuss concerns or questions with the ERCVFD personnel directly involved with the response or any ERCVFD officer. I also understand that resources may be available to assist me after a call of particular significance, if required.

_____
Name (Printed)

_____
Signature

_____
Date

_____ _____
Fire Chief Signature Date

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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?	☐	☐	

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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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Conditions of Membership

I understand that to become a member of the East Roane County Volunteer Fire Department I must pass or present the items listed below and the respective results.

_____ If this is for a first time membership request I understand that I will be on a 6 month probation period before I become a permanent member.

I understand that if I have conditional membership screening results returned with failing results, the East Roane County Volunteer Fire Department will

1. Not accept me as a member.
2. I could be placed on probation until proper documentation matches the results.
3. Ask me to resign my membership.

I also understand that if I am accepted as a member and any of the following information is found to be false or misleading, my membership will be terminated. I also understand that if any information I have given on my application is found to be false or misleading my membership may cause me to be terminated.

_____ Criminal Background Check

_____ Drug Screen

_____ Motor Vehicle License

_____
Name (Printed)

_____
Signature

_____
Date

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MEMBERSHIP TRAINING REQUIREMENTS

Training Requirements	Hours
Members Onboarding	1
Radio Communications	1
IS-100.C: Introduction to the Incident Command System, ICS 100	2
IS-200.C: Basic Incident Command System for Initial Response, ICS-200	4
IS-700.B: An Introduction to the National Incident Management System	3.5
IS–800.D: National Response Framework, An Introduction	3
Hazardous Materials Awareness	16
Hazardous Materials Operations	16
MERTT (Modular Emergency Response Radiological Transport)	8
Driver Training IAFF Emergency Vehicle & Roadway Scene Safety	4
BBP Blood Borne Pathogens	4
DV Domestic Violence	4
CISM Critical Incident Stress Management	4
CPR Card By AHA (Basic Life Support Provider)	8
Intro to FF J&B Introduction to Fire Fighting	16
Basic Firefighting	64
Monday Night Training (3 Per Month)	9
Monday Night Station Checks (1 Per Month)	3
Third Saturday Monthly Training	3
FFC Firefighter 1 Live Burn	8
Emergency Medical Responder (Option Provided)	160
Total Hours	333.5

All the listed ICS classes can be found at the FEMA website after an account has been created.
https://trainging.fema.gov/emi.aspx

Drivers Training, Blood Borne Pathogens and DV Domestic Violence can be found at https://www.tnfiretrainging.com/moodle/ after an account has been created.

All highlighted training is required for all probationary members.

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Standard Training and Meeting

1st Monday of the month training night – Location to be announced starts at 18:00 HRS (6PM)

2nd Monday of the month – Station / equipment checks at your assigned station starts at 18:00 HRS (6PM)

2nd Thursday of the month Board of Directors meeting location to be announced.
Board of Directors meeting starts at 18:00 (6:00PM)
All members and public are welcome to the meeting

3rd Monday of the month training night – Location to be announced starts at 18:00 HRS (6PM)

3rd Saturday of the month training day – Location to be announced – starts at 09:00 HRS (9AM)

4th Monday of the month training night – Location to be announced starts at 18:00 HRS (6PM)

No training on the 5th Monday of the month.