



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 <input type="checkbox"/> No <input type="checkbox"/>		
If Yes , Where :		
Do you have any special training in this field? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If Yes, Please Specify:		
Are you willing to adhere to department policies as prescribed by our By-Laws, SOP and SOG's? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 workers compensation claim reporting.
- I agree to follow all safety procedures and regulations that relate to the performance of my employment with the East Roane County Volunteer Fire Department.
- I understand that I must report all on the job injuries to my fire chief within 24 hours.
- I was given an workers compensation claim reporting worksheet.

Signature: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Is peripheral (side) vision restricted?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Is color perception impaired?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Do you have, or have you ever had Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Are actual deficiencies corrected by glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Date of last eye examination:			
2. HEARING			
a. Do you have difficulty hearing at a normal conversation level?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Do you use a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Describe condition:			
c. Describe current medication and dosage, if any:			
d. Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Date of last treatment or check-up:			
5. EPILEPSY			
a. Have you ever been treated for Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
b. If "Yes," when was your last seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Describe current medication and dosage, if any:			
6. LUNGS			
a. Have you ever been treated for Asthma or COPD?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Have you lost the use of an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Does vehicle have special controls?	<input type="checkbox"/>	<input type="checkbox"/>	
d. If "Yes," to any of the above, describe:			
9. MISCELLANEOUS			
a. Have you ever had, or been treated for, Convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	
b. If "Yes," give date of last treatment and describe current medication and dosage, if any:			
c. Have you ever had any Fainting Spells?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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.

I also understand that if I am accepted as a member and any of the following information is found to be false on the application or misleading can lead to membership will be terminated.

_____ Criminal Background Check

_____ Drug Screen

_____ Motor Vehicle Driving History State DL: _____ DL #: _____

Name (Printed)

Signature

Date

Roane County Sheriff's Office



Sheriff Jack Stockton

230 N. Third Street
Kingston, Tn 37763

Phone: (865) 376-5582
Fax: (865) 717-4766

Background Check

Person/Business Requesting Record EAST ROANE Co. VOLUNTEER FIRE DEPARTMENT

Name _____
Last First Middle Maiden

Address _____
Road/Street Name and Number

City _____ State _____ Zip _____

DOB _____ SSN _____ Sex _____ Race _____


Signature of Person Requesting Record

DO NOT WRITE BELOW THIS LINE

Local Records Check _____

Roane County Arrest Cards: _____ No Record _____ Records Found (Attached)

Background Check by _____ 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://training.fema.gov/is/crslist.aspx?lang=en>

Drivers Training, Blood Borne Pathogens and DV Domestic Violence can be found at

<https://www.tnfiretraining.com> 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 1800 HRS (6PM)

2nd Monday of the month – Station / equipment checks at your assigned station starts at 1800 HRS (6PM)

3rd Monday of the month training night – Location to be announced starts at 1800 HRS (6PM)

4rd Saturday of the month training day – Location to be announced – starts at 0900 HRS (9AM)

5th Monday of the month training night – Location to be announced starts at 1800 HRS (6PM)

No training on the 5th Monday of the month.

Quarterly business meeting is the 1st Monday of the month
location to be announced.

Business meeting starts at 1830 (6:30PM) All Members and Public are welcome.