

# Application For Employment

## Tyger River Fire Department

355 Locust St.  
Lyman, SC 29365  
864-949-6061

The Tyger River Fire Department appreciates your interest in becoming a member of this department whether by career or volunteer. The application is the first step in the selection process. If you are applying for a career position whether full-time or part-time, you will not be considered for the position unless you have completed this application to the fullest and meet the minimum qualifications for the position being applied for. No information provided will be used for any other purpose other than the consideration for employment. The Tyger River Fire Department is an equal opportunity employer, and no applicant will be removed from consideration based on race, color, religion, gender, national origin, age, marital or veteran status, the presences of a non-job-related medical condition or handicap, or any other legally protected status. However, a candidate must be able to successfully pass a medical evaluation and be in good physical condition to perform the duties as a firefighter. A medical evaluation will be assessed by a doctor that department chooses to use.

**Application must be completed in its entirety to be considered. A resume may be submitted but not in place of any fields of the application. Application needs to be completed in Blue or Black ink. Please Print in all Fields. If additional space is needed, please make a note on the page, and add additional information on the 2 blank pages supplied.**

Position Applied For: \_\_\_\_\_ Date of Application: \_\_\_\_\_

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Name: \_\_\_\_\_

Last

First

Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Home

Work

Cell

Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Class: \_\_\_\_\_ State: \_\_\_\_\_

Have you ever applied with us before? \_\_\_\_\_ if so, when? \_\_\_\_\_

Have you ever been employed with us before? \_\_\_\_\_ if so, when? \_\_\_\_\_

Do you have any family members currently employed with us? \_\_\_\_\_

If so, who? \_\_\_\_\_

Are you at least 18 years of age? \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you legal to work in the Unites States? \_\_\_\_\_

Have you ever been arrested? \_\_\_\_\_ If so, when and for what? \_\_\_\_\_ Have you ever been convicted of a felony? \_\_\_\_\_

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**Education**

	High School	College/University	Graduate/ Professional
School Name and Location			
Years Completed			
Diploma/ Degree Course of Study			

Describe any specialized Training: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate any Foreign Languages that you can speak, read, and/or write:

	Fluent	Good	Fair
Speak			
Read			
Write			

List any professional trade, business, or civic offices or activities participated current or in the past.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently serving in any of the United States branches of Military? \_\_\_\_\_

If so, which branch? \_\_\_\_\_

Have you previously served in any of the United States branches of Military? \_\_\_\_\_

If so, which branch? \_\_\_\_\_

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## Employment History

Starting with your most recent or current employment, please provide us with detailed information. If you need additional space, please use the blank sheets provided. Include any time that may have been when you were in school if there is a gap in employment history.

Employer: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Supervisor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ May we Contact? \_\_\_\_\_  
Job Duties: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Supervisor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ May we Contact? \_\_\_\_\_  
Job Duties: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Supervisor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ May we Contact? \_\_\_\_\_  
Job Duties: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Supervisor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ May we Contact? \_\_\_\_\_  
Job Duties: \_\_\_\_\_  
\_\_\_\_\_

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**References**

Provide us with 3 references that we may contact. Please do not use a family member or a previous employer.

Name: \_\_\_\_\_ Years Known: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

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Name: \_\_\_\_\_ Years Known: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

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Name: \_\_\_\_\_ Years Known: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Special Skills & Qualifications**

Summarize any special skills or training that you have acquired from other places of employment that you feel will help you succeed with our department.

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**Medical Questionnaire**

**Emergency Contact:**

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**RESPOND with YES or NO ANSWERS**

**1) Eyesight:**

Have you lost use of either eye? \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_

Do you have peripheral vision restrictions? \_\_\_\_\_ If Yes, Explain \_\_\_\_\_

Are you color blind? \_\_\_\_\_

Do you have or ever had cataracts? \_\_\_\_\_

Do you wear corrected vision? \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Date of Last eye exam? \_\_\_\_\_

**2) Hearing**

Do you have difficulty hearing normal conversation? \_\_\_\_\_

Do you use a hearing aid? \_\_\_\_\_

**3) Diabetes**

Have you ever been treated for diabetes? \_\_\_\_\_

Describe any medication you take \_\_\_\_\_

Date of last blood sugar test/ A1C \_\_\_\_\_ Results \_\_\_\_\_

**4) Heart**

Have you ever had a heart attack or cardiac episode? \_\_\_\_\_ If so, When? \_\_\_\_\_

Dr. Name and Location: \_\_\_\_\_

Are you currently taken or prescribed cardiac medications? \_\_\_\_\_

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**Medical Questionnaire (Contd.)**

Do you have a pacemaker? \_\_\_\_\_

Have you had any cardiac related care? \_\_\_\_\_ If so When and for what? \_\_\_\_\_

**Epilepsy**

Have you ever been treated for epilepsy? \_\_\_\_\_ If so, when was last seizure? \_\_\_\_\_

Describe any current medications or treatments \_\_\_\_\_

**Blood Pressure**

Have you ever been treated for high blood pressure? \_\_\_\_\_ If so, when? \_\_\_\_\_

Date Last Checked: \_\_\_\_\_

What was your last blood pressure? \_\_\_\_\_ / \_\_\_\_\_

Describe any medications or treatments \_\_\_\_\_

**Limbs (to include hands, feet, legs, and arms)**

Have you lost an arm or leg? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Have you had any surgeries to a limb? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Have you lost the use of any of your limbs? \_\_\_\_\_ If so, what % \_\_\_\_\_

Have you ever had any Hand, Arm, Shoulder, Leg, or Foot surgery in the past? \_\_\_\_\_

If so, explain when and why? \_\_\_\_\_

Do you have any Prosthetics or Internal Fixators (plates, pins, screws etc.)? \_\_\_\_\_

If any of these were answered yes, please describe in detail: \_\_\_\_\_

**Miscellaneous:**

Do you have a history of fainting spells? \_\_\_\_\_

Do you have any chronic back pain? \_\_\_\_\_

Do you have any chronic pain or conditions in arms, legs, knees, shoulders? \_\_\_\_\_

Have you ever had a drug or alcohol problem? \_\_\_\_\_

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**Medical Questionnaire (Contd.)**

Have you ever been treated for mental illness? \_\_\_\_\_

Have you ever had any surgeries? \_\_\_\_\_

If any of these were answered yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

What was the date of your last physical exam? \_\_\_\_\_

Have you ever had a DOT physical? \_\_\_\_\_

Have you ever had a firefighter physical? \_\_\_\_\_ If so, results? \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_ If so, why? \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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**Applicant's Statement**

**I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. This application for employment shall be considered active for a period not to exceed 6 months whether applications are being accepted at that time.**

**I hereby understand that, unless otherwise defined by applicable law, any employment relationships with this organization are of an "at will" nature, which means that the employee may resign at any time and the employer may discharge the employee at anytime with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.**

**In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand also that I am required to abide by all policies of the employer.**

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**Signature of Applicant**

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**Date**

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**Voluntary Information**

**(Please Print)**

Qualified applicants are considered for all positions, and employees are treated fairly during employment without regard to race, color, religion, gender, national origin, age, marital or veteran status, medical condition, or handicap. . However, a candidate must be able to successfully pass a medical evaluation and be in good physical condition to perform the duties as a firefighter. A medical evaluation will be assessed by a doctor that department chooses to use.

As employers, we comply with government regulations and affirmative action responsibilities.

Solely, to help us comply with government record keeping, reporting and other legal requirements, please fill out the data record.

This data is for periodic government reporting and will be kept in a confidential file separate from the application for employment AND IS STRICTLY VOLUNTARY.

Date: \_\_\_\_\_

Position Applied for: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Affirmative Action Survey**

**Government agencies require periodic reports on the gender, ethnicity, handicapped, and veteran status of applicants. This data for analysis and affirmative action only. Submission of information about a handicap is voluntary.**

**Check One:**             **Male**                     **Female**

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**Check One:**  **White**     **African American**     **Hispanic**  
 **American Indian/Alaskan Native**     **Asian/ Pacific Islander**

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**Check Any That Apply:**     **Vietnam Era Veteran**     **Handicapped Individual**  
 **Disabled Veteran**

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