FLORISSANT FIRE PROTECTION DISTRICT

2606 W. HIGHWAY 24 / P.O. BOX 502
FLORISSANT, COLORADO 80816-0502
Phone: 719-748-3909 / FAX: 719-748-5342

Membership Application
Cover Sheet

The Florissant Fire Protection District (FFPD) requires the following of all employees / volunteers:

Item	**Initial**
1. Authorization to inquire of an applicant's references and others, concerning the Applicant's qualifications and character.	_______
2. A release of liability benefiting all persons the FFPD contacts regarding the Applicant's background.	_______
3. Authorization for drug testing prior to, and during employment in accordance with the FFPD Drug Testing Policy.	_______
4. An acknowledgement that employment is at-will and thus, that Termination may be at any time with or without cause, prior notice, or appeal and that only the Board can change the at-will relationship.	_______
5. All employees/volunteers must state any past criminal convictions relevant to the position sought.	_______
6. The Applicant agrees to abide by the rules, regulations and policies of the Department as well as those of the Florissant Fire Protection District, and acknowledges that the same may be changed at any time.	_______
7. The Applicant has the necessary licenses and insurance to meet the State's requirements for the position Sought; a copy of which will be maintained in the Department's files.	_______
8. The Applicant agrees to notify the Chief of any changes regarding licenses or insurance.	_______
9. EMS Applicants acknowledge they have read and understand the Colorado Functional Position Statement (attached).	_______

This application is true and complete to the best of my knowledge and belief. I understand that falsification of any information contained herein is grounds for termination at any time.

Applicant's Signature:____ Date:________

Please continue on next page ☞

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Membership Application

Date:____________________

Applicant's Name:____

Address:____
Mailing address (if different):____

Home phone:_________________________Work phone:___________________________________

Driver's license (State & #):___________________ Soc. Sec. # :___________________

Date of birth:_________________________Place of birth:___________________________

Height:____________Weight:___________Eye color:__________Hair color:_______________

Employer:____
Address:____Phone: __________________

Previous employer (if less than one year with current employer):
Name: ____
Address:____Phone: __________________

Formal education (highest grade completed):_________________

Length of time in Florissant area:___________________________

Spouse's name:____

References – list FIVE other than current employer
Name:____Phone:___________________
Address:____
Name:____Phone:___________________
Address:____
Name:____Phone:___________________
Address:____
Name:____Phone:___________________
Address:____
Name:____Phone:___________________
Address:____

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Medical History: Do you have any type of medical conditions which might limit your ability to perform during strenuous fire-fighting or rescue operation? ❑ YES ❑ NO
If yes, please explain: (note: membership in the Department is not denied on the basis of physical handicap).____

____

____

Firefighter and/or emergency medical experience or certifications: (note: please furnish copies of licenses or certifications, to be filed in the Department's records). ______________________

____

____

Have you ever used illegal drugs, including amphetamines, depressants, tranquilizers, cocaine, or marijuana? ❑ YES ❑ NO If yes, please explain: ______________________

____

____

To what extent do you use alcoholic beverages?______________________________

Have you ever been treated for alcoholism or drug abuse? ❑ YES ❑ NO If yes, give name and location of hospital or institution and dates of treatment or commitment:____________

____

____

Have you ever been arrested for any reason (include traffic arrests or tickets)? ❑ YES ❑ NO
If yes, give details:____

____

____

Has your driver's license ever been revoked, suspended or denied? ❑ YES ❑ NO
If yes, give details:____

____

____

Have you ever been denied motor vehicle insurance, or has your motor vehicle insurance ever been cancelled? ❑ YES ❑ NO If yes, give details:__________________________

____

____

Please continue on next page ☞

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Person to contact in case of an emergency - Name:____________________________________
Phone(s): home:________________work:___________________cell:____________________

EMERGENCY PROFILE

This information will be used in the event of your injury or illness while in service. The only persons authorized to access this profile data are Department Officers or Incident Commanders, and then only at such time as the information is specifically required. It is intended to be used if a medical situation arises whereby you are unable to provide this data to the above individuals and/or medical personnel effecting your medical treatment.

Every member must have an emergency profile on record, even if you elect to leave the profile blank. The information requested is voluntary: complete all areas of information that you desire.

Name: Last:_________________________First:___________________Middle:____________
Social Security Number:___________________________
Mailing Address:____
Street Address:____
Home Phone: _______________________Work Phone:________________________
Physician's Name:________________________________ Phone:___________________
Blood Type:_____________ Hospital Preference:______________________________
Allergies:____
____
____

Medical History (chronic conditions, diseases, surgeries, etc.):___________________________
____
____
____
____

Medications (type and dosage):____
____
____
____
____

Signature:____ Date:______________