NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION

1711 Route 34 South • Wall Township, New Jersey 07727-3934
Telephone: (732) 798-8137 • (800) 852-0137

THIS NOTICE IS FOR YOUR INFORMATION.
Privacy Notice for our (Potential) Members – Please review it carefully

The New Jersey State Firefighter's Association (NJSFA) and each Officer and the Office Staff and all the Local Associations throughout the state strongly believe in protecting the confidentiality and security of the information we receive about you. This notice refers separately to the New Jersey State Firefighter's Association and each of the Local Associations by using the terms "us", "we", or "our". This notice describes our privacy policy and describes how we treat the information we receive about you.

Why We Receive and How We Use Information: We receive the initial information via a Membership Application and Physical Test Record, Form #100. The purpose of this application is to permit membership in our organization. This information is used to make sure the applicant is in compliance with New Jersey Statutes and our Compendium and By-Laws.

How We Receive Information: We get most of the information from you. The Secretary of the Local Relief Association forwards the application form to our office. The information that you give us when applying for membership generally provides the information we need. If we need to verify information or need additional information, we may obtain information from third parties such as physicians, hospitals, and other medical personnel. Information collected may relate to your health or other information stated on the application.

How We Protect Information: We treat information in a confidential manner. Our Officers, Advisory Committee and Office Staff are required to protect the confidentiality of information. We access information only when there is an appropriate reason to do so. We also have safeguards to protect information. All Officers, Advisory Committee members and Office Staff are required to comply with our policies.

Information Disclosure: We may disclose any information when we believe it necessary for the operation of our Association, or where disclosure is required by law. The application if in question may be forwarded to our Association Medical Doctor for evaluation. We do not make any other disclosures of information to other organizations or companies who may want to sell their products or services to you. We will not sell your name or application information to any organization, corporation, or catalog company.

Access to and Correction of Information: Generally, upon written request, we will make available your personal information for your review. Information received in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. This will be included under "Disclosure of Information."

AFTER COMPLETING YOUR PHYSICAL, SEPARATE THIS SHEET FROM THE APPLICATION AND PHYSICAL PAGE. PLEASE RETAIN THIS PAGE AND DO NOT RETURN IT TO YOUR LOCAL ASSOCIATION OR TO THE STATE OFFICE.

ONCE COMPLETED, RETURN THE ATTACHED APPLICATION/PHYSICAL TO YOUR LOCAL RELIEF ASSOCIATION SECRETARY.

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PHYSICAL EXAMINATION GUIDELINES

VALID FOR ONE (1) CALENDAR YEAR FROM THE DATE OF THE PHYSICAL

1. AGE: Must be at least 18 years of age and not older than 57 years of age.
2. EYES: Must be 20/50 corrected, monocular vision permitted (with glasses, contacts, or surgical procedures).
3. HEARING: Loss of hearing acuity so as to be unable to perceive sounds within normal voice range with or without hearing aid.
4. NOSE: Any significant nasal obstruction to free breathing not subject to correction by surgery.
5. MOUTH: Conditions which impair the ability to communicate.
6. NECK: Problems resulting from (a) Goiter; (b) Limited range of motion, which prohibits turning, extension or free movement of the neck; (c) Tracheotomy – existing openings at the lower portion of the neck connecting the windpipe to the outside environment for the purpose of easy breathing.
7. PULMONARY: Problems resulting from (a) Loss or removal of a lung; (b) Any pulmonary disorder which would limit the applicant's ability to perform; (c) Pulmonary Function Test below normal; (d) Chronic Obstructive Pulmonary Disease/Asthma.
8. CARDIO PULMONARY SYSTEM: Problems resulting from Heart Disease or Cardiomegaly.
9. PERIPHERAL VASCULAR SYSTEM: Problems resulting from (a) Varicose veins; (b) Aneurysms; (c) Lymphedema; (d) Thrombophlebitis; (e) Arteriosclerosis Obliterans; (f) Buerger's Disease; (g) Raynaud's Disease; (h) Arterio-Venous Fistula; (i) High Blood Pressure, not able to be corrected by medication. Acceptable blood pressure reading should be as follows (a) Systolic not higher than 140 but not lower than 80; (b) Diastolic maximum should be 100 mmhg and minimum 50 mmhg.
10. ABDOMEN: Problems resulting from (a) Organomegaly; (b) Signs of tenderness in an area; (c) Presence of masses such as hernias of various types.
11. GENITOURINARY SYSTEM: Problems arising from (a) Presence of abnormal masses; (b) Abnormal discharges from any of the orifices; (c) Active venereal Diseases; (d) Parasitic diseases; (e) Varicocele and Varices; (f) Hydrocele.
12. MUSCOLO-SKELETAL SYSTEM: Problems arising from (a) Congenital malformation; (b) Limitation of Motion; (c) Weakness; (d) Impairment or absence of one or more of the digits on either or both hands; (e) Impairment of function of the hands; (f) Missing toes if it interferes with ambulation; (g) Deformities of the spine, pelvis or extremities.
13. OTHERS: Problems arising from (a) Disqualification for psychiatric conditions must be determined by local agencies; (b) Allergic conditions which are chronic and incapacitating; (c) Severe Anemia; (d) Active Peptic Ulcer; (e) Diabetes; (f) History of epilepsy or seizures other than documented febrile convulsions in childhood; (g) Alcoholism or drug addiction; (h) Removal of vital organs; (i) Any other condition not listed above which would render the applicant incapable of performing their duties as a firefighter.

THESE MEDICAL GUIDELINES ARE TO BE FOLLOWED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT LICENSED IN THE STATE OF NEW JERSEY WHEN EXAMINING AN APPLICANT FOR MEMBERSHIP. ANY ABNORMAL FINDINGS MUST BE EXPLAINED IN THE REMARKS SECTION OF THE APPLICATION. ALL SECTIONS OF THE PHYSICAL MUST BE COMPLETELY AND PROPERLY FILLED OUT OR THE APPLICATION WILL BE RETURNED.

ASSOCIATION #	COMPANY #	LINE #
FOR STATE OFFICE USE ONLY		

New Jersey State
Firefighter's Association
Application for Membership

Form 100 – REV 9/25

Date _____

_____ _____ _____ _____
Relief Association Name | Assoc. Number | Municipality | County

_____ _____
Fire Company Name | Fire Department Name

Applicant Name _____
First | Middle Initial | Last | Suffix

Home Address _____ _____
Street | Municipality | Zip Code | # of years

Date of Birth _____ Birth Place _____ SS # _____
(REQUIRED)

Applicant Phone Number _____ Applicant Email Address _____

Have you ever been charged with, pled guilty to, or been convicted of a crime involving and/or including arson: ☐Yes ☐No

Have you ever applied to be a member of the NJSFA? ☐Yes ☐No If yes, when _____ where _____

If you have a line number with another Relief Association: ☐ Stay with previous Association ☐ Move records to new Association

*** <u>It is the Applicant's responsibility to notify their Local Relief Secretary of any address change throughout their career/membership.</u> ***

I CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUTHFUL, COMPLETE AND ACCURATE. I AM AWARE THAT IF ANY OF THE INFORMATION PROVIDED ABOVE IS FALSE, I AM SUBJECT TO PUNISHMENT UNDER THE LAW.

Signature of Applicant (witnessed by a Notary Public): _____

State of New Jersey, County of _____,

On _____, 20_____ before me, _____, Notary Public in and for said county, personally appeared

_____, (signer) who has satisfactorily identified himself/herself as the signer to the above referenced document.

My Commission Expires: _____ _____ (Affix Notary Stamp Here)
Notary Public Signature

_____ _____
Signature of Relief Association Secretary | Signature of Chief of Department

Type of Firefighter the Applicant will be: ☐ Career (full time paid) ☐ Volunteer

Municipal/Fire District Approval: I hereby certify that this applicant was admitted to active membership in the Department and has been approved by the governing body of _____ on the ____ day of _____, 20_____.

Signature of Municipal Clerk/Board of Fire Commissioners: _____

A. Application portion should be completed by Applicant – Typed or Printed ONLY.
B. Application must have the Physical Test Record completed by a New Jersey Licensed Physician, Nurse Practitioner or Physician Assistant.
C. The completed Application and Physical Test Record must be returned to the Local Relief Secretary.
D. The Local Relief Secretary shall review the application for completeness, attain the proper signatures, and forward to the NJSFA State office.

The Applicant is not a member of the NJSFA until the completed application is received AND approved at the NJSFA State office. Email to Localreports@njsfa.com or fax to (732) 938-2580. Original hard copy no longer required.

Physical Test Record (Valid for one (1) year from the Date Examined)

To be filled out by a Physician, Nurse Practitioner or Physician Assistant that is licensed in the State of New Jersey. Once the Physical has been completed, this form must be returned to the Local Relief Association Secretary at the address listed below.

All sections of the Physical must be properly filled out. If improperly filled out or questions are left blank, the Physical will be returned for correction or completion. NO SECTION CAN BE LEFT BLANK.

Please Print

Name _____ _____
First Middle Initial Last Sex

☐ W. N. L.

Age _____ Height _____Ft. _____In. Weight _____ Lbs. Hearing: ☐ Other: _____ BP _____
(Numbers Please)

Eyesight: Left_____ Right _____ Both (Corrected) _____
(Numbers Please) (Monocular Vision Permitted)

Has Applicant any apparent disabilities in:

Facial _____ Pulmonary _____

Cardio Pulmonary_____ Vascular _____

Abdomen _____ Genitourinary _____

Musculo-Skeletal _____ Other _____

The Applicant is free of any, other than listed above, medical or physical conditions that would cause harm to him/her or any other firefighter(s): ☐ YES ☐ NO (If no, explain below)

Has Applicant ever suffered from injury? ☐ YES ☐ NO If so, what and when? _____

Remarks / or rejection is based on: _____

I CERTIFY THAT AS A PRACTICING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT LICENSED IN THE STATE OF NEW JERSEY, THE APPLICANT IS FREE FROM ANY ACUTE OR CHRONIC DISEASE AND HAS NO PHYSICAL DEFECTS THAT WOULD HINDER HIS/HER ABILITY TO PERFORM THE DUTIES OF A FIREFIGHTER.

Date Examined _____ Examined at _____
Address of office

☐Physician
☐Nurse Practitioner
☐Physician Ass't

_____ _____ _____
Examiner's Phone # Print Examiner's Name Signature of Examiner

* If a Nurse Practitioner or Physician Assistant, please indicate the name of the collaborating or supervising physician *

_____ _____
NPI Number Print Physician's Name

THE NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION RESERVES THE RIGHT TO HAVE THIS APPLICATION REVIEWED BY A MEDICAL DOCTOR OF ITS CHOICE, INCLUDING A NEW PHYSICAL EXAMINATION IF NECESSARY.

This Application/Physical must be returned to the local Relief Association Secretary:

_____ _____ _____
Local Relief Secretary Name Address Zip code