APPLICATION FOR MEMBERSHIP

Today's Date: _____________

Type of Membership: ❑ Firefighter ❑ Medical ❑ Associate ❑ Cadet* (junior)

Name: ____ Age: ________
Address: ____
Home Phone: ________________________ Cell Number: ____________________
E-mail Address: ___________________________
Driver's License Number: ___________________________

- Do you live in the Sullivan Gardens Area, City of Kingsport, Colonial Heights, Bloomingdale or Fall Branch? ❑Yes ❑No
- Do you agree to pull one twelve (12) hour shift per month and attend trainings regularly? ❑Yes ❑No
- Do you agree that if you fail to attend a class the department has paid for, without a proper excuse, that you will reimburse the department for your class fees? ❑Yes ❑No
- Do you agree to read, adhere and sign-off on the department's operating guidelines? ❑Yes ❑No

If you answered no to any question, explain:
____
____

- Do you have any firefighting experience? ❑Yes ❑No
- Do you have any medical training? ❑Yes ❑No
- Are you currently a member of an emergency service? ❑Yes ❑No

If you answered yes to any question, explain:
____
____

Copies of certificates will be needed if your membership is accepted.

- Do you have any medical conditions which would require special consideration? ❑Yes ❑No
- Are you currently under a physician's care? ❑Yes ❑No

If you answered yes to any question, explain:
____
____

- Would you be willing to take a physical at the expense of the department? ❑Yes ❑No

- Do you have a police record? (felonies and/or misdemeanors) ❑Yes ❑No
- Do you have a driving record? ❑Yes ❑No

If you answered yes to any question, explain:
____
____

- Do you agree to allow us to perform a background check? ❑Yes ❑No
- Would you be willing to take a drug test at the expense of the department? ❑Yes ❑No

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DEPARTMENT USE ONLY
DATE OF MEMBERSHIP COMMITTEE INTERVIEW: ________________
DATE APPLICATION WAS BROUGHT IN FRONT OF BOARD: ________________
WAS MEMBER ACCEPTED? ❑YES ❑NO IF NOT, GIVE REASON: ________________________________
STIPULATIONS TO MEMBERSHIP: ____
ASSIGNED CAPTAIN: ____

REFERENCES

DEPARTMENT USE

REFERENCE 1

Name of reference:______________________________
Association with reference:______________________________
Contact number:______________________________
Best time to call:______________________________

REFERENCE 2

Name of reference:______________________________
Association with reference:______________________________
Contact number:______________________________
Best time to call:______________________________

REFERENCE 3

Employer:______________________________
Position/Responsibilities:______________________________
Employer's Phone Number:______________________________
Supervisor's Name:______________________________
Best time to call:______________________________

ADDITIONAL REFERENCES

EMERGENCY SERVICE REF.

If you have been, or currently are, a member of another emergency service, complete.
We do not accept applications from members of other volunteer fire departments.

Name of service:______________________________
Dates of service:______________________________
Responsibilities or rank obtained:______________________________
Name of supervising officer (Captain or Chief):______________________________
Contact number:______________________________
Best time to call:______________________________

LEGAL GUARDIAN REFERENCE

If you are under the age of 18 and applying for cadet/junior membership, complete.
Your parents must be present when your application is being voted on.
Parent or Legal Guardian:______________________________
Contact Number:______________________________
Best time to call:______________________________

APPLICATIONS MAY BE REJECTED IF AT LEAST THREE REFERENCES ARE NOT GIVEN.

CRIMINAL BACKGROUND CHECK

Sullivan County Sheriff's Office

P.O. Box 589
Blountville, TN 37617
Telephone (423) 279-7500
Fax (423) 279-7613

Sullivan County, Tennessee
Criminal Records Search

Applicant should complete ONLY this section

I here-by request and authorize to the Sullivan County Sheriff's Office the release of all criminal information concerning the person listed below.

Complete Name: ____
last name first middle

Maiden name and other possible names: ______________________________

Address: ____

City: ______________________ State: _____ Zip: ____________

Social Security Number: _______-_____-________ Date of Birth ____/____/________

Signature: ____

List of criminal records located:

____

____

____

____

____

____

____

____

This record includes only charges from arrests for which the person was booked into the Sullivan County Correctional Facility and from misdemeanor citations served by officers of the Sullivan County Sheriff's Office. The person may have charges in other jurisdictions, including the cities of Bluff City, Bristol and Kingsport, that could not be located in a search of this agency's records. The person may also have charges that have been expunged by court order. Any records with regard to juvenile status are not public record and are not included.

This record may include charges that have been dismissed. Contact the appropriate court clerk for information on the deposition of any charges listed.

For more complete information, have a criminal records search conducted in each jurisdiction where the person would be likely to have charges, including cities located within Sullivan County.

PLEASE NOTE: DUE TO COMPUTER TECHNICAL PROBLEMS, THIS RECORDS SEARCH DOES NOT COVER ANY TIME PERIOD PREVIOUS TO 1999. We apologize for the inconvenience.

Signature of clerk: ______________________________________ Date ____/____/________

FAX TO: 423-279-7613 ONLY BY AN AUTHORIZED REPRESENTATIVE

DRIVING RECORD CHECK

Authorizing consumer reports and/or driving records to be obtained - signed by volunteer

Sullivan West VFD
113 Rosemont Drive
Kingsport, TN 37660

Re: MVR Reports

To Whom It May Concern:

Consumer reports may be obtained as part of the Sullivan West VFD evaluation of my application to drive emergency vehicles owned and operated by Sullivan West VFD. The reports may be procured by J. Mark Bowery Insurance, and may included my driving record, an assessment of my insurability under the company's insurance coverages or other consumer reports. By signing this disclosure, I hereby authorize the company to procure such reports and additional reports about me from time to time, as it deems appropriate, to evaluate my insurability or for other permissible purposes.

Sincerely,

____
Signature of Volunteer

Please Print As Shown On Your Driver's License

Name of Volunteer	State of Driver's License
Street Address	Driver's License Number
City, State, Zip Code	Date of Birth

IF YOUR MEMBERSHIP IS ACCEPTED, THIS SHEET WILL BE PLACED IN YOUR MEMBER FILE.

VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization ______________________________ State __________

Member's /Employee's Name ______________________________

Member's Date of Birth ______________ Date Member Joined Organization ______________

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name ______________________ Relationship __________ Date of Birth__________ Share________%

Name ______________________ Relationship __________ Date of Birth__________ Share________%

Contingent
Beneficiary: Name ______________________ Relationship __________ Date of Birth__________ Share________%

Name ______________________ Relationship __________ Date of Birth__________ Share________%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature______________________________ **Date** ______________________

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

Specifying Beneficiaries

Individual (always show relationship to the insured)	***Primary Beneficiary**	****Contingent Beneficiary**	Second **Contingent Beneficiary**
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

C01:008A

IF YOUR MEMBERSHIP IS ACCEPTED, THIS SHEET WILL BE PLACED IN YOUR MEMBER FILE.

APPRENTICESHIP AGREEMENT

ANY APPLICANT WHO ALREADY HAS THEIR STATE FIREFIGHTER ONE TRAINING OR HIGHER SHOULD PROVIDE PROOF OF CERTIFICATION.

The department agrees to the non--disciminatory training of apprentices (new members) in accordance with the terms and conditions of the Tennessee Commission of Firefighting's personnel standards and education apprenticeship and training program. The apprentice agrees to participate in the department's training program and to test for his or her state firefighter certification after meeting the needed r equirements.

The terms of this agreement shall be at least three (3) years beginning at the member's acceptance.

Name: ____ Date of Birth: ________
Address: ____
Social Security Number: ______________________

STATE CERTIFICATIONS USE SOCIAL SECURITY NUMBER FOR IDENTIFICATION PURPOSES. THIS INFORMATION IS KEPT CONFIDENTIAL AND IN UNDER LOCK AND KEY.

ACCEPTANCE OF TERMS

The information provided in this application is true to the best of my knowledge. Furthermore, I have read and understand the terms of the apprenticeship agreement and probationary membership and agree to adhere to them.

Signature: ____ Date: _____________

*Signature of parent or legal guardian:____
(Any applicant under the age of 18 must have the consent of his or her parent or legal guardian)

AFFIRMATION OF APPLICANT'S ACCEPTANCE

Chief's Signature: ____ Date: _____________

Chairman's Signature: ____ Date: _____________