TAYLORSVILLE-SPENCER COUNTY FIRE PROTECTION DISTRICT
108 WATER STREET
TAYLORSVILLE, KENTUCKY 40071
(502) 477-3228
Revised 5/1/2020

VOLUNTEER APPLICATION

Minimum Requirements

1. Able to read, write, and understand the English language based on educational attainment or experience;
2. Not in violation, and has not been in violation within the last five (5) years, of driving under the influence or public intoxication;
3. Not convicted of a felony offense;
4. A citizen of the United States, a permanent resident of the United States, or otherwise lawfully present in the United States, as evidenced of a driver's license, birth certificate, a United States Permanent Resident Card, or other legal authorization to live and work in the United States,
5. Eighteen (18) years of age or older. Must provide a copy of your driver's license and or both certificate

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For Fire Officials Only (Yes or No)

1. _____Is this person able to read, write, and understand the English language based on educational attainment or experience;

2. _____Has this person been in violation within the last five (5) years, of driving under the influence or public intoxication;

3. _____Has this person ever been convicted of a felony offense;

4. _____Is this person a USA citizen, a permanent USA resident, or otherwise lawfully present in the USA;

5. _____Copy of driver's license provided;

6. _____Copy of birth certificate provided;

7. _____Beneficiary Designation From completed;

8. _____Medical Statement Form completed;

9. _____Copy of automobile proof of insurance provided;

10. _____Is this person at least 18 years of age;

11. _____Has background been completed with Administrative Office of the Courts

12. _____Denied or accept this person's application;

13. _____Has person completed drug screening as required.

_____

Officer

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VOLUNTEER APPLICATION

PRINT OR TYPE IN INK. Fill out all sections COMPLETELY and ACCURATELY. Your application will be used as part of the examination process and therefore, should represent your best effort. Unsigned or incomplete applications will not be considered. FALSE answers may lead to rejection of application and/or dismissal. Once submitted, application materials become property of the Taylorsville-Spencer County Fire Protection District. Attach additional pages if needed. The Taylorsville-Spencer County Fire Protection District does not accept FAXED applications. Photocopied applications must have an original signature and current date. Please write the letters "NA" (Not Applicable) in those sections, which do not apply, to you. Attach additional pages if needed.

CURRENT INFORMATION

(1) Date of Application: _____

(2) NAME: _____
(First) (Last) (Middle)

(3) ADDRESS: _____
Street & No. or P.O. Box City State Zip

(4) HOME PHONE # ( )_____ CELL. PHONE #. ( )_____

E-MAIL ADDRESS: _____

(5) Social Security Number _____

(6) Date of Birth _____

(7) Are you 18 years of age or older? [ ] Yes [ ] No _____

(8) List all other names, including maiden name and nicknames, by which you are known or have been known.

(9) List all former addresses you have had during the past five years.

GENERAL INFORMATION

If you need to explain any answers, use the space under EXPLANATIONS near the end of this application.

(10) Have you ever been volunteered with the Taylorsville-Spencer County Fire Protection District? [ ] Yes [ ] No
If YES, when:_____

(11) Have you ever applied to the Taylorsville-Spencer County Fire Protection District? [ ] Yes [ ] No
If YES, indicate what position and when:_____

(12) Are you now or were you previously related in any way to a Fire Department volunteer or employee? [ ] Yes [ ] No
If YES, give name and relationship:_____

(13) Are you able to perform all of the duties of the job you have applied for? [ ] Yes [ ] No

(14) Do you have any allergies or other significant medical conditions [ ] Yes [ ] No
If yes, please describe here _____

(15) List all Traffic and criminal convictions:

Charge	Location (City/State)	Date	Disposition of Charge

(16) Have you even been convicted of a felony? If YES, please explain under EXPLANATIONS. [ ] Yes [ ] No
(A "YES" will not automatically disqualify you from consideration.)

(18) Are you an American citizen or do you currently have authorization to work in the U.S.? [ ] Yes [ ] No

(19) Did you receive any of your education or employment experience under another name? [ ] Yes [ ] No
If YES, please explain under EXPLANATIONS.

EDUCATION

Provide your complete history

(20) Indicate highest school year completed: (i.e. 8, 12, 16) _____

(21) Name of High School_____ City_____ State_____

22) Have you received a high school diploma or equivalent? [ ] Yes [ ] No

Education Beyond High School	Name and Location	Attended From Mo.	Yr.	Mo.	Yr.	Did You Graduate?	Credit Hours	Degree, Diploma Certificates Earned or No. of Years	Major Minor
College(s) University(ies)									
Graduate or Professional Schools									
Technical Institutions, Internship, Other									

(Please provide a copy of your High School Diploma, GED, or High School Transcript with your completed application)

KNOWLEDGE, SKILLS & ABILITIES

(23) Please list any knowledge, skills or abilities you have that you feel are applicable to the position for which you are applying. Include Skills with equipment or machines you can operate. If you wish consideration for a secretarial/clerical position, indicate typing speed and word processing software packages known and/or used.

(a)_____ (e)_____
(b)_____ (f)_____
(c)_____ (g)_____
(d)_____ (h)_____

REGISTRATION, LICENSES & CERTIFICATIONS

(24) If you currently are or have been a KY firefighter please list your KY Firefighter Number: _____

(25) List fields of work for which you have been registered, licensed or certified:

Registration:_____ State:_____ No:_____ Exp. Date:_____

Registration:_____ State:_____ No:_____ Exp. Date:_____

Other:_____

(Please provide a copy of any certifications with your completed application)

(26) Please list your **VALID DRIVER'S LICENSE NUMBER** and the state in which it was issued. If you do not have a drivers license please put "NONE" in the blank – **Number:**_____ **State:**_____
Expires: _____
(Please provide a copy of your driver's license with your completed application)

(27) Is your driver's license a Commercial Drivers License? [ ] Yes [ ] No

EMPLOYMENT

Begin with your most recent job and describe in detail each specific job you have had in the last fifteen (15) years. Periods of unemployment should also be noted. Leave no gaps in time sequence. Be sure to list all applicable experience, which qualified you for the position sought. If needed, additional sheets containing the same information and in the same format are acceptable. Include military and related volunteer experience. Be sure to account for gaps in your employment history. **ALL SPACES MUST BE COMPLETED OR MARKED N/A (not applicable). "See attached resume" is NOT acceptable in the duties space. Please attach additional sheets if needed.**

If you have previous firefighting experience from fire agencies, please list them below. If the position was volunteer, please list VOLUNTEER in the salary section.

A. CURRENT OR MOST RECENT EMPLOYMENT (or explain gap in employment)

JOB TITLE_____Starting Salary_____Last Salary_____
Date employed_____Date separated_____
Employer or company_____Telephone # (____)_____
Employer or company address_____
Name and title of most current supervisor_____
Full-time for: Yrs.___ Mos.____ Part-time for: Yrs___ Mos.____ # of employees supervised by you_____
If you worked part-time, the number of hours worked per week _____
DUTIES IN ORDER OF IMPORTANCE_____
_____
_____
_____
REASON FOR LEAVING or desiring change_____

B. CURRENT OR MOST RECENT EMPLOYMENT (or explain gap in employment)

JOB TITLE_____Starting Salary_____Last Salary_____
Date employed_____Date separated_____
Employer or company_____Telephone # (____)_____
Employer or company address_____
Name and title of most current supervisor_____
Full-time for: Yrs.___ Mos.____ Part-time for: Yrs___ Mos.____ # of employees supervised by you_____
If you worked part-time, the number of hours worked per week _____
DUTIES IN ORDER OF IMPORTANCE_____
_____
_____
_____
REASON FOR LEAVING or desiring change_____

(28) Have you ever had disciplinary action taken against you? [ ] Yes [ ] No
If YES explain under EXPLANATIONS. (A YES will not automatically disqualify you.)

(29) a). Have you ever been dismissed or forced to resign from any job held? [ ] Yes [ ] No
b).Were you dismissed or forced to resign for disciplinary reasons? [ ] Yes [ ] No
If YES to "a" or "b" , explain under EXPLANATIONS (A YES will not automatically disqualify you.)

(30) May we contact your present employer for reference prior to an interview (if granted)? [ ] Yes [ ] No
If you are not currently employed, please check here N/A____. If NO explain under EXPLANATIONS.

(31) Have you ever served in the military? [ ] Yes [ ] No
If Yes, complete the following:

Dates:	Branch:	Rank at time of Discharge:
From:	To:	

(32) Were you honorably discharged ? _____ Yes _____ No
If NO explain under EXPLANATIONS. (A NO will not automatically disqualify you).

REFERENCES

List the name, address and telephone number of three (3) persons who are not related to you and are not previous employers, who have known you for at least two (2) years.

_____

_____

_____

How did you learn about this position?

_____Personal Contact _____Website _____TV _____Outdoor Sign

_____Other: _____

_____Taylorsville-Spencer County Firefighter (Name of Firefighter) _____

EXPLANATIONS

ITEM # _____

Certification and Release (MUST BE SIGNED AND DATED BELOW)

- To the best of my knowledge and belief, the information given truly represents my background and experience. I understand that if I have knowingly or negligently misrepresented, falsified or omitted any information during the application process, or have made any changes to the format or wording of this application form, I may be disqualified for employment consideration or dismissed from membership with the Fire Department.
- I authorize my current and former employers to give any information regarding my employment, or me whether or not it is on their records. I hereby release them from any damage whatsoever for issuing the same.
- I also authorize educational institutions, which I attended to reveal my scholastic ratings, as well as degrees or certificates earned, to the Taylorsville-Spencer County Fire Protection District and associations, registration and licensing boards and to others to furnish whatever detail is available concerning my qualifications. Notwithstanding any provision of State or Federal law, I expressly waive any right I have to review the information the Taylorsville-Spencer County Fire Protection District receives from an employer or educational institution under a promise of confidentiality.
- I also permit the Taylorsville-Spencer County Fire Protection District to conduct a Police, Court, Credit and/or Motor Vehicle Records Investigation of my background.
- I understand I will be tested for drug and alcohol to determine if I am currently abusing these substances. I consent to the testing and understand that the results could preclude my appointment.
- I understand and acknowledge that should I be employed (paid or volunteer) by the Taylorsville-Spencer County Fire Protection District, then I serve a 18 month probation period, as outlined by departmental policy, and I may be terminated at any time with or without cause.

SIGNATURE_____ **DATE**_____

VFIS®
A Division of Glatfelter Insurance Group

Annual Medical Statement of Personnel

NOTE: 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. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained.

Questions:

Name: _____

Address: _____

City & State: _____ Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Social Security No. _____

What is your Valid State Operators Plate No. _____

REMARKS: If any question is answered, "YES," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

1. Birth Date: Month: _____ Day: _____ Year: _____

	Yes	No
2. Eyesight:		
a. Have you lost use of either eye? _____ R _____ L.....a.	☐	☐
b. Is peripheral (side) vision restricted?.....b.	☐	☐
c. Are you color blind?.....c.	☐	☐
d. Do you have, or have you ever had, cataracts?.....d.	☐	☐
e. Are actual deficiencies corrected by glasses or contact lenses?...e.	☐	☐
f. Date of last eye examination:.....f.	_____	
3. Hearing:		
a. Do you have difficulty hearing normal conversation level?.....a.	☐	☐
b. Do you use a hearing aid?.....b.	☐	☐
4. Diabetes:		
a. Have you ever been treated for diabetes?.....a.	☐	☐
b. Describe current medication and dosage, if any, and method of administration under "remarks."		
c. Date of latest blood sugar test:.....c.	_____	
5. Heart:		
a. Have you ever been treated for heart disease?.....a.	☐	☐
b. Describe condition:.....b.	_____	
c. Describe current medication and dosage, if any, under "remarks."		
d. Do you have a pacemaker?.....d.	☐	☐
e. Date of last treatment or check-up:.....e.	_____	
6. Epilepsy:		
a. Have you ever been treated for epilepsy?.....a.	☐	☐
b. If "Yes," when was your last seizure?.....b.	_____	
c. Describe current medication and dosage, if any, under "remarks."		

Questions:

REMARKS:

	Yes	No
7. Blood Pressure:		
a. Have you ever been treated for high blood pressure? ....a.	☐	☐
b. If "Yes," when were you treated? ....b.	_____	
c. What was your last reading? ....c.	_____	
d. Describe current medication and dosage, if any, under "remarks."		
8. Limbs:		
a. Have you lost an arm or leg? ....a.	☐	☐
b. Have you lost the use of an arm or leg? ....b.	☐	☐
c. Does vehicle have special controls? ....c.	☐	☐
d. If "Yes" to any of the above, describe under "remarks."		
9. Miscellaneous:		
a. Have you ever had, or been treated for, Convulsions? ....a.	☐	☐
b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
c. Have you ever had any Fainting Spells? ....c.	☐	☐
d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
e. Have you ever had, or been treated for, Loss of Equilibrium? ....e.	☐	☐
f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
g. Have you ever been treated for Alcohol or Drug Abuse? ....g.	☐	☐
h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
i. Have you ever been treated for Mental Illness? ....i.	☐	☐
j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."		
10. What is the date of your last physical examination?	_____	
11. Are there any restrictions posted on your vehicle operator's license?	☐	☐
12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?	☐	☐

13. When and for what purpose, did you last consult a doctor?

_____

_____

14. Full Name, address and telephone number of your personal physician.

Name: _____

Address: _____

City & State: _____ **Zip:** _____

The answers to the above are complete, accurate, and true to the best of my knowledge.

_____ _____

Signature of Person Named Above **Date**

Authorization For Release

"I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give _____ _____ Department/Company any such information."

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

_____ _____

Signature of Person Named Above **Date**

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.