Name:				Date:		
Address:	City:			State:	Zip:	
Home Ph:	Cell Ph:			e-Mail:		
D.L. #	Cl	Class:		Issue State:		
S.S.#	Sex: () Male	() Female B	lood Typ	e:		
D.O.B N	larital Status: () Ma	rried () Single	Heigh	nt:	Weight:	
Hair Color:	Eye Color:		Ra	ce:		
Physician's Name:			Physicia	n's Ph:		
Allergies:			14			
In Case of Emergency Notify:						
Address:					Zip:	
Home Ph:	·	City: State: Zip:				
Eyesight:		Yes	No		Remarks	
Have you lost use of either eye?						
Is peripheral (side) vision restricted?				Y		
Are you color blind?	1	4				
Do you have, or have you ever had, ca	itaracts?					
Are actual deficiencies corrected by g	asses or contact lenses?	PA				
Date of last eye examination?	1 61		1/6		77 /2	
				Y		
Hearing:		Yes	No	-	Remarks	
Do you have difficulty hearing normal	conversation level?			7		
Do you use a hearing aid?				1	700 m	
	//					
Diabetes:		Yes	No	F	Remarks	
Have you ever been treated for diabe	tes?					
Describe current medication and dosa	ge, if any, and method of					
administration under "remarks"						
Date of latest blood sugar test:						
				//	-0	7/
Heart:		Yes	No	F	Remarks	//
Have you ever been treated for heart	disease?	'				/ _
Describe condition:	15					
Describe current medication and dosa	ge, if any, under "remarks."					-
Do you have a pacemaker?						
Date of last treatment or check up		111				
	10) ~ /		
Epilepsy:	115 0	DES		F	Remarks	
Have you ever been treated for epilep	sy?	KE-				
If "yes" when was you last seizure?						

1212		- 0	
Blood Pressure:	Yes	No	Remarks
Have you ever been treated for high blood pressure?			
If "Yes" when were you treated?			
What was your test reading?			
Describe current medication and dosage, if any, under remarks			
_			
Limbs:	Yes	No	Remarks
Have you ever lost an arm or leg?			
Have you lost the use of an arm or leg?			
Does vehicle have special controls?			
If "Yes" to any of the above, describe under "remarks."			
	_		
Miscellaneous:	Yes	No	Remarks
Have you ever had, or been treated for, Convulsions?			
If "Yes" give data of last treatment and describe current medication and		•	
dosage, if any, under "remarks." Have you ever had any Fainting Spells?	+	1	
If "Yes" give date of last treatment and describe current medication and	+	1	
dosage, if any, under remarks."			
Have you ever had, or been treated for, loss of Equilibrium?			
If "Yes" give date of last treatment and describe current medication and			
dosage, if any, under remarks." Have you ever been treated for Alcohol or Drug Abuse?			
7			
Have you ever been treated for Mental Illness?			
If "Yes" give date of last treatment and describe current medication and			
dosage, if any, under remarks."			
What is the date of your last physical examination?			
Are there any restrictions posted on your vehicle operator's license?			
Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?			
Will you submit to a physical exam, if requested by the Department to do	+		
50?			
Have you ever been convicted of a felony?			
Have you previously been a paid or volunteer Fire Dept. member?			
If "Yes" please give the name of Dept., Chief, and Phone No. in Remarks.			
Have you had training in CPR?	<u> </u>		
Have you been trained as a First Responder?	<u> </u>		
Have you been trained as a EMT?	<u> </u>		
If "Yes", is your certification current?	<u> </u>		
Are you willing to attend classes?	<u> </u>		
Did someone ask you to join the Fire Department? If so, Who?			

All members of this Department must be 18 years of age (16 for junior members) and reside within District 3 or be within 7 miles of any District Station.

I UNDERSTAND THAT THIS IS A VOLUNTEER DEPARTMENT AND THAT THERE ARE RULES AND REGULATIONS THAT MUST BE OBSERVED. I AM ALSO AWARE THAT I MAY BE SUBJECT TO RANDOM DRUG TESTING, AND DRIVER'S LICENSE BACKGROUND CHECK CONDUCTED. ANY MISUSE OF THE DEPARTMENT EQUIPMENT OR FAILURE TO COMPLY WITH THE REGULATIONS SET BY THIS DEPARTMENT WILL RESULT IN DISCIPLINARY ACTION OR DISMISSAL.

Furthermore, 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 Allen parish Fired District 3 any such information.

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

I hereby certify that I have received a copy of all the rules and regulations, have read them, and fully

understand them.

Signature of Applicant	Date

Parent/Guardian consent fo	or applicants under 18 years of age.
I,, give	e my consent for
To become a Jr. Member of Allen Parish Fire Di	strict 3 Volunteer Fire Department.
Signature of Parent/Guardian	Date

Fire Chief Date

Approved / Rejected

	Item		Condition	Remarks
	Radio			
	Make:			
Handheld	Radio			
Radio	Model			
	Radio			
	Serial #			
	Radio			
	Make:			
Mobile	Radio			
Radio	model:			
	Radio			
	Serial #			
		Issued/Size	Condition	Remarks
	Helmet:			
	Jacket:			
	Pants:			
Bunker	Boots:			
Gear	Hood:			
	Gloves:			
	Bag:			
T-Shirt				
Size				
l				e aforementioned equipment to use in
the execution	on of my duti	es as a member of A	llen Parish Fire Dist	rict 3. If I resign from or am removed

	acknowledge receiving the aforementioned equipment to use in
the execution of my duties as	a member of Allen Parish Fire District 3. If I resign from or am removed
from duty for any reason I will	return said equipment.
	d carrier here I am requesting my cell phone number be added to the list text message when we receive a page.
Cell Phone Number:	Phone Carrier:
	Signature of Volunteer: