

Howe Springs Fire Rescue

4395 S. Irby Street Florence, SC 29505
Phone: (843) 669-4196 Fax: (843) 669-1557

Attached is my application for membership with the Howe Springs Fire Department. By signing my name below I consent to the required investigation of all items listed, and not listed, in this application. I also consent to the interview of myself and of any references provided herein, and to any background investigations needed, by any law enforcement agencies.

I understand that I am subject to an agility test, a physical examination and drug screenings.

I understand that should any information found herein be investigated and found to be false, or exaggerated, that I will be subject to immediate dismissal from the Howe Springs Fire Department.

I understand that if I live outside of the district boundaries the Howe Springs Fire Department President and / or Board of Directors have the authority to deny my application if deemed I cannot be an asset to the department.

Applicant's Signature

Date of Application

Initial below as it applies. Before the application is complete the statements must apply to your application, be true and have your initials signed beside each.

_____ I am 18 years of age, or older, or I will be within the next 30 days. (Full Membership Only)

_____ I have completed the attached application to the best of my knowledge and ability.

_____ I have included my 10 year driving record from the South Carolina DMV.

_____ I have included copies of my high school diploma or GED. Junior Members submit your most recent report card or progress report.

OFFICE USE ONLY

Date Received:	Date Contacted:	Contacted By:	Background Check: <input type="checkbox"/> Clear <input type="checkbox"/> Not Clear
Comments:			
Interview Date:		HSFD Board's decision:	Date of decision:

Application for Membership

Please print all information in black or blue ink. Do not use cursive letters or pencil.

<i>Personal Information</i>					
Last Name:		First Name:		Middle Name:	
Current Address (No. PO Boxes):				Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
City:		Zip:		Height:	Weight:
Home Phone:		Work Phone:		Cell Phone:	
Date of Birth :		Place of Birth:		Social Security Number:	
Drivers License #:		License Class:	State:	U. S. Citizen: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Select all that apply: <input type="checkbox"/> SUPPORT <input type="checkbox"/> FIRE FIGHTER <input type="checkbox"/> DRIVER / OPERATOR <input type="checkbox"/> ADMINISTRATION <input type="checkbox"/> MEDICAL FIRST RESPONDER <input type="checkbox"/> AUXILIARY <input type="checkbox"/> JUNIOR					
Marital Status (check one): <input type="checkbox"/> SINGLE <input type="checkbox"/> ENGAGED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED					
<i>Military Service & Employment History</i>					
Military Service Branch:		Enlistment Date:	Discharge Date:	Discharge Type:	
Present Employer:		Supervisor's Name:		Supervisor's Phone:	
Work Address:				Position Held:	
City:		State:	Zip:	How long at this job?	
Work Schedule: STRAIGHT DAYS STRAIGHT NIGHTS		Shift Length:	8 HR SHIFT 10 HR SHIFT 12 HR SHIFT		
STRAIGHT EVENINGS SHIFT WORKER		OTHER:			
If less than 5 years with your present employer please list previous employers for the last 5 years. List the most recent employers first.					
Employer Name:		Address:		Phone #:	Reason for Leaving:
Employer Name:		Address:		Phone #:	Reason for Leaving:
Employer Name:		Address:		Phone #:	Reason for Leaving:
Employer Name:		Address:		Phone #:	Reason for Leaving:
Employer Name:		Address:		Phone #:	Reason for Leaving:
<i>References</i>					
List any former or current members of the Howe Springs Fire Department that you are acquainted with:					
List four (4) references, other than relatives, excluding the members listed above.					
Name		Address (Street, City, State, Zip)		Phone Number	

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Background Information

Have you ever been arrested for a felony? YES NO If yes, list what you were arrested for, when and where.

Have you ever been convicted of a felony? YES NO If yes, list what you were convicted of, when and where.

Have you been arrested for a misdemeanor? YES NO If yes, list what you were arrested for, when and where.

Have you been convicted of a misdemeanor? YES NO If yes, list what you were convicted of, when and where.

Are you now, or have you ever been, under investigation, indictment, or on probation for a felony or misdemeanor? YES NO
If yes, explain on the reverse side of this page.

Medical History

List any medical surgeries, disabling injuries, or bodily organ loss:

List and describe any scars, physical marks or tattoos you have:

List all medications:

Have you ever been treated for, do you currently have, or have you have any of the following conditions? This section must be completed, with all conditions checked as Yes or No. Explain all conditions which are answered as yes on the reverse side of this page.

Black out spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Unconsciousness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Color blindness	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizziness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High / Low blood	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Eye trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Drug / Narcotic Use	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Artificial Eye	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Head injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Alcohol / Drinking Problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Artificial Limb	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Back Pain / Injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Muscle Spasms	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures (Any type)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Arm / Foot / Leg cramps	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Severe Headaches / Migraines	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Fear of Heights	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Trick shoulder / limb	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Claustrophobic	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Eardrum Rupture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Abdominal Rupture	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hearing loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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<i>Education</i>				
Institution	State	Begin Date	End Date	Did you graduate? <small>(If still attending please write "Attending")</small>
High School				
High School				
College / University				
College / University				
If you did not graduate from high school, have you obtained a G.E.D. certificate? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<i>Fire Fighting Experience and Training</i>				
Are you now, or have you previously, been a member of another fire department? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If yes, please list them below, with the most recent first.				
Department / Company Name	Address	Begin Date	End Date	
Are you currently a volunteer member of another Fire Department? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Have you applied for membership with the Howe Springs Fire Rescue before? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If yes, please provide when:				
Have you attended any fire fighting schools previously? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If yes include copies of any certifications you have received with the application				
List Fire Fighting and Medical Classes completed: (1152, Fire Fighter 1 / 2, Officer 1 / 2, First Responder, EMT, Paramedic)				
1.	9.			
2.	10.			
3.	11.			
4.	12.			
5.	13.			
6.	14.			
7.	15.			
8.	16.			