



HONORARY MEMBERSHIP APPLICATION
(PLEASE PRINT)

Full Name _____ Social Security # _____

Address _____ City _____ State _____

Phone Number _____ Number of years at this address _____

Number of years in community _____ Previous Address _____

E-Mail Address _____

Birth Date _____ Single _____ Married _____

Have you ever been a member of any fire company? _____

If yes, state name of company and dates _____

List three (3) references:

Name _____ Address _____

Phone _____

Name _____ Address _____

Phone _____

Name _____ Address _____

Phone _____

Employment Firm _____ Address _____

Phone _____ Your Position _____

Years Employed _____ Name of Supervisor _____



Police Violations, if any _____

Are you presently on disability? _____

If yes, describe reason _____

Have you ever received Workman's Compensation of disability insurance? _____

If yes, describe reason _____

Do you now, or have you ever, had heart problems? _____

Recommended by members:

Investigating Committee:

I give the Volunteer Hose Company Board of Directors permission to investigate me now or in the future. If elected, I promise to obey all the by-laws, rules, and regulations now in force or that hereafter may be adopted.

Signed _____

Office Use Only

Date Application Received _____

Date of First Reading _____

Date Voted Upon _____

Accepted _____

Rejected _____



Underage Authorization

I hereby give my/our permission for _____ to become a member of the Volunteer Hose Company of Middletown, since he/she is under the legal age of 18.

Parent or Guardian

Date

Application Fee

I understand that there is an application fee of \$20.00. I have enclosed the aforementioned fee with this application in the form of cash or check.

Applicant

Date

Parent or Guardian



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: _____

- 2. Eyesight:**
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Have you lost use of either eye? _____ R _____ L.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is peripheral (side) vision restricted?.....b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you color blind?c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have, or have you ever had, cataracts?.....d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are actual deficiencies corrected by glasses or contact lenses?...e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Date of last eye examination:.....f. | | _____ |

- 3. Hearing:**
- | | | |
|---|--------------------------|--------------------------|
| a. Do you have difficulty hearing normal conversation level?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you use a hearing aid?b. | <input type="checkbox"/> | <input type="checkbox"/> |

- 4. Diabetes:**
- | | | |
|--|--------------------------|--------------------------|
| a. Have you ever been treated for diabetes?a. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe condition:.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |
| d. Do you have a pacemaker?d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Date of last treatment or check-up:e. | | _____ |

- 6. Epilepsy:**
- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for epilepsy?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when was your last seizure?.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |

Questions:

REMARKS:

- 7. Blood Pressure:**
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Have you ever been treated for high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when were you treated? | _____ | |
| c. What was your last reading? | _____ | |
| d. Describe current medication and dosage, if any, under "remarks." | | |

- 8. Limbs:**
- | | | |
|--|--------------------------|--------------------------|
| a. Have you lost an arm or leg? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you lost the use of an arm or leg?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does vehicle have special controls? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes" to any of the above, describe under "remarks." | | |

- 9. Miscellaneous:**
- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever had, or been treated for, Convulsions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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

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.



Parental Consent for Physical/Drug Screening

I hereby give my permission for my son/daughter, _____,

to receive a physical/drug screen (circle one or both) from Christiana Care Occupational Health Services. I certify that I am the minor's parent or legal guardian.

Please note **“photo ID is required for this service.”**

Signature of Parent/Guardian

Date