Sheppton-Oneida Volunteer Fire Company
P.O. Box 275, 900 Center Street
Sheppton, PA 18248
East Union Township
Phone/Fax: (570) 384-4746
www.sovfc.com

APPLICATION FOR MEMBERSHIP

Application Type:

◯ Active Membership ◯ Auxiliary Membership

Demographic Information

Last Name:_____ First Name: _____ MI:_____

Address:_____ City: _____ State: _____

Zip Code:_____ Phone Number: _____ Date of Birth:_____

Driver's License Number:_____

List any medical conditions that you have that may interfere with active or auxiliary membership :

_____

List any criminal convictions:

_____

List other emergency service organizations that you are affiliated with:

_____

List emergency service training that you have completed:

_____

Emergency Contact:

Name: _____ Relationship: _____

Address:_____ City:_____ State:_____

Zip Code: _____ Phone Number:_____

Personal References:

1. Name: _____ Relationship: _____
   Address: _____ City: _____ State: _____
   Zip Code: _____ Phone Number: _____
2. Name: _____ Relationship: _____
   Address: _____ City: _____ State: _____
   Zip Code: _____ Phone Number: _____
3. Name: _____ Relationship: _____
   Address: _____ City: _____ State: _____
   Zip Code: _____ Phone Number: _____

Fire Company Sponsors:

1. Name: _____ Title: _____

   Signature:_____

2. Name: _____ Title: _____

   Signature: _____

Disclaimer

I certify that the above information is true and accurate to the best of my knowledge and that failure to disclose any of the above information may affect my eligibility for membership within the Sheppton-Oneida Volunteer Fire Company. I am aware that the Sheppton-Oneida Volunteer Fire Company does not discriminate on the basis of age, sex, race, ethnic origin, sexual orientation, or any other means. I understand that the Sheppton-Oneida Volunteer Fire Company requires a screening physical examination by a licensed medical practitioner, on the attached form, in order to be considered for membership. I understand that two (2) active fire company members must sponsor and sign this application prior to being submitted to the Sheppton-Oneida Volunteer Fire Company for consideration of membership. I authorize the Sheppton-Oneida Volunteer Fire Company to contact my list of references and conduct a criminal background investigation. I understand that this application is made available for review by the Fire Chief, Deputy Fire Chief, Assistant Fire Chief, and Trustees of the fire company after being successfully voted upon for review at a regular meeting and prior to being considered for membership by the body of the Sheppton-Oneida Volunteer Fire Company at the subsequent meeting. I understand that my membership in the Sheppton-Oneida Volunteer Fire Company is also contingent upon my following of the fire company's bylaws, rules of order, and standard operating guidelines which will be made available for my review. I understand that I will serve a one (1) year probationary period during which I cannot vote for officers or hold office. I understand that any keys, equipment, pagers, or radios issued to me remain fire company property and will be returned if my membership is terminated or at the request of the fire chief or fire company. I further swear that I have never been convicted of an offense that constitutes the crime of "arson and related offenses" under 18 Pennsylvania .C.S 3301 (Act 168 of 2006) or any other similar offense under any Federal or State Law.

Applicant Signature: _____ Printed Name:_____ Date: _____
(parent must also sign if applicant is under age 18)

Parent Signature:_____ Printed Name: _____Date:_____

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OATH OF ALLEGIENCE

I, _____, promise to uphold the constitution and by-laws of the Sheppton-Oneida Volunteer Fire Company.

To carry out the duties of my office and/or membership to the best of my ability.

To carry out the orders and responsibilities as directed by by-laws, standard operating guidelines, and officers of the Sheppton-Oneida Volunteer Fire Company.

To care for and protect all Fire Company equipment and property.

To care for and protect all personal equipment assigned to me by the Sheppton-Oneida Volunteer Fire Company

To report equipment damaged or missing to proper fire company officers.

To help maintain the building and grounds of the Sheppton-Oneida Volunteer Fire Company.

To keep the business and discussions of the Sheppton-Oneida Volunteer Fire Company confidential.

To uphold the highest respect and dignity for my membership within the Sheppton-Oneida Volunteer Fire Company.

To train and prepare for emergency response to provide the best possible community service.

To serve the residents and visitors of East Union Township to the best of my ability.

If I should resign, become inactive, or be dismissed from membership, I will return all property of the Sheppton-Oneida Volunteer Fire Company within five (5) days to the proper fire company officers. If not returned, I shall be subject to charges or judgements filed against me.

_____ _____

Member Signature **Witness Signature**

_____ _____

Member Printed Name **Witness Printed Name**

_____

Date

Sheppton-Oneida Volunteer Fire Company Use Only:

(Chiefs)

Meeting Date: _____

Chiefs Present: _____

Recommendations: _____

(Trustees)

Meeting Date: _____

Trustees Present: _____

Recommendations: _____

(President)

Date Application Submitted: _____

Date of 1st Meeting Reviewed: _____

Accepted: _____ Denied: _____

Comments:_____

Date of 2nd Meeting Reviewed: _____

Accepted: _____ Denied: _____

Comments:_____

President's Signature:_____

President's Printed Name: _____

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MEDICAL EXAMINATION TO DETERMINE FITNESS FOR FIREFIGHTER TRAINING

Name:_____ Date of Birth: _____ Date of Exam:_____

For the medical professional conducting the examination: The purpose of this examination is to ensure that the physical, physiological, intellectual, and psychological health of the applicant is suitable for the environment and functions of a firefighter as described on page 2. This medical examination must be completed by a physician, surgeon, physician assistant or certified registered nurse practitioner.

Examination should include but is not limited to:

Dermatological system, Cardiovascular system, Clinical evaluation of 12 lead EKG, Systolic and Diastolic Blood pressure, Respiratory system, Gastrointestinal system, Endocrine and metabolic systems, Neurological system, Ears/eyes/nose/mouth/throat, Auditory hearing in the pure tone, Far visual acuity corrected or uncorrected, Peripheral vision, Genitourinary system, and Musculoskeletal system.

For the medical professional conducting the examination to complete:
Based on the results of this medical evaluation, the applicant: (check appropriate box)

( ) Has no pre-existing or current condition, illness, injury or deficiencies. The applicant is medically fit to engage in firefighter training and firefighting.

( ) Has a pre-existing or current condition, illness, injury or deficiency that presents a safety or health risk in the environment or functions of a firefighter. The applicant is not medically fit for firefighter training or firefighting.

( ) Has a pre-existing or current condition, illness, injury or deficiency that presents a safety or health risk in the environment or job functions of a firefighter. The applicant is able to participate in firefighter training but with the conditions listed on reverse.

Attestation (please print):

Provider Signature: _____ Date signed: _____

Provider Printed Name: _____ Degree: _____

Office Phone: _____

Office address: _____

Essential Job Tasks and Descriptions from NFPA 1582, 2007 edition

1. Performing firefighting tasks (e.g., hose line operations, extensive crawling, lifting, carrying heavy objects, ventilating roofs or walls using power or hand tools, and forcible entry), rescue operations and other emergency response actions under stressful conditions while wearing personal protective ensembles and self-contained breathing apparatus (SCBA), including working in extremely hot or cold environments for prolonged time periods.
2. Wearing an SCBA, which includes a demand valve–type positive-pressure face piece or HEPA filter masks, which requires the ability to tolerate increased respiratory workloads.
3. Exposure to toxic fumes, irritants, particulates, biological (infectious) and non-biological hazards, and/or heated gases, despite the use of personal protective ensembles and SCBA.
4. Climbing six or more flights of stairs while wearing fire protective ensemble weighing at least 50 lbs. or more and carrying equipment/tools weighing an additional 20 to 40 lbs.
5. Wearing fire protective ensemble that is encapsulating and insulated, which will result in significant fluid loss that frequently progresses to clinical dehydration and can elevate core temperature to levels exceeding 102.2°F.
6. Searching, finding, and rescue-dragging or carrying victims ranging from newborns up to adults weighing over 200 lbs. to safety despite hazardous conditions and low visibility.
7. Advancing water-filled 2 ½ diameter hose lines from fire apparatus to occupancy [approximately 150 ft.], which can involve negotiating multiple flights of stairs, ladders, and other obstacles.
8. Climbing ladders, operating from heights, walking or crawling in the dark along narrow and uneven surfaces, and operating in proximity to electrical power lines and/or other hazards.
9. Unpredictable emergency requirements for prolonged periods of extreme physical exertion without benefit of warm-up, scheduled rest periods, meals, access to medication(s), or hydration.
10. Operating fire apparatus or other vehicles in an emergency mode with emergency lights and sirens.
11. Critical, time-sensitive, complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed spaces, that is further aggravated by fatigue, flashing lights, sirens, and other distractions.
12. Ability to give and comprehend verbal orders while wearing personal protective ensembles and SCBA under conditions of high background noise, poor visibility, and drenching from hose lines and/or fixed protection systems (sprinklers), hear alarm signals, hear and locate the source of calls for assistance from victims or other firefighters.
13. Functioning as an integral component of a team, where sudden incapacitation of a member can result in mission failure or in risk of injury or death to civilians or other team members.

Background Checks

Question: Who needs required background checks? Answer: Act 153 of 2014 requires periodic background checks for both employees and volunteers who are directly involved with children. Under law, volunteers must obtain the clearances if they have direct volunteer contact, meaning they have care, supervision, guidance or control AND routine interaction with children. This is the standard that will apply to determine whether an adult volunteer must get the background checks every five years. The two main clearances are the Department of Human Resources child abuse clearance and the state police criminal background check. The fees for these checks are waived for volunteers and are reduced to $8 each for employees.

PA State Police Background Check: https://epatch.pa.gov/home

Child Abuse Clearance: https://www.compass.state.pa.us/CWIS/Public/Home

You will have to create an account to complete your child abuse clearance. At the end of the application there will be a spot to enter a code so you do not have to pay for the check. Your unique code is:

SP 4-164A (12-2020)

PENNSYLVANIA STATE POLICE

REQUEST FOR CRIMINAL RECORD CHECK

VOLUNTEER ONLY

1-888-QUERYPA (1-888-783-7972)

This form is to be completed in ink by the requester – (information will be mailed to the requester only). If this form is not legible or not properly completed, it will be returned unprocessed to the requester.

TRY OUR WEBSITE FOR A QUICKER RESPONSE
https://epatch.pa.gov

REQUESTER NAME	
ADDRESS	
CITY/STATE/ ZIP CODE	
TELEPHONE NO. (AREA CODE)	

FOR CENTRAL REPOSITORY USE ONLY
CONTROL NUMBER

AFTER COMPLETION MAIL TO:

PENNSYLVANIA STATE POLICE
CENTRAL REPOSITORY – RCPU
1800 ELMERTON AVENUE
HARRISBURG, PA 17110-9758

SUBJECT OF RECORD CHECK

(FIRST)	(MIDDLE)	(LAST)		
MAIDEN NAME AND/OR ALIASES	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH (MM/DD/YYYY)**	**SEX**	**RACE**

VOLUNTEER'S AGENCY/ORGANIZATION (MANDATORY)	TELEPHONE NUMBER

The Pennsylvania State Police response will be based on the comparison of the data provided by the requester against the information *contained in the files of the Pennsylvania State Police Central Repository only.*

By signing this form, I verify that I am submitting this request for criminal history record information in connection with my status as an unpaid volunteer. I understand that the $22 fee is being waived because of my status as an unpaid volunteer.

REQUESTER SIGNATURE (*Signature required for processing*)	DATE

WARNING: 18 Pa.C.S. 4904(b) UNDER PENALTY OF LAW - MISIDENTIFICATION OR FALSE STATEMENTS OF IDENTITY TO OBTAIN CRIMINAL HISTORY INFORMATION OF ANOTHER IS PUNISHABLE AS AUTHORIZED BY LAW.

Homeland Security is Everyone's Responsibility - Pennsylvania Terrorism Tip Line 1-888-292-1919

Offered by:

PROVIDENT

Beneficiary Designation Form for Group Accident & Health and Group Life and Group Accidental Death & Dismemberment Insurance

Axis Insurance Company
Life Insurance Company of North America
Cigna Life Insurance Company of New York

Instructions: As a member of your organization you are eligible for benefits under group insurance policies offered by Provident Agency, Inc. You have the right to name a beneficiary. If you choose **not** to name a beneficiary, or if all named beneficiaries die with or before you, the death benefits may be payable to in the order listed below:

a. spouse;
b. child or children, equally, if living, otherwise to their descendants per stirpes;
c. parents, equally or to the survivor;
d. sisters or brothers, equally or to the survivor or survivors;
e. your estate.

If you would like to name a specific beneficiary(ies), then you need to complete this form. Completed beneficiary designation forms should be filed with your organization.

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits. Please specify the percentage of the benefit you want to be paid to each primary beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want to be paid to each contingent beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies)** - When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust** - You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **A&H** is Accident & Health insurance provided by your organization for which they pay the premiums.

- **Group Life** is life insurance provided by your organization for which they pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation** - You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney** - This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

Beneficiary Designation Form for Group Accident & Health and Group Life and Group Accidental Death & Dismemberment Insurance

Axis Insurance Company Life Insurance Company of North America
Cigna Life Insurance Company of New York

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Completed beneficiary designation forms should be kept on file with your organization.**

Section 1: Policyholder Information

Organization Name			Phone	
Organization Address	City	County	State	Zip

Section 2: Member Information

Name (Last Name, Suffix, First Name, MI)	Date of Birth	Social Security #

Check the coverages to which this beneficiary designation form applies. ☐ A&H ☐ Group Life ☐ AD&D ☐ All

Section 3: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 4: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies) of the insurance benefits that may be payable at the time of my death.

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 5: Signature

X _____ _____

Member Signature Date