POQUETANUCK FIRE DEPARTMENT

87 Rte 2A Preston, Ct 06365

Please fill in application in ink or type. Answer all questions in full and return.

I hereby apply for_____ (*Active or Associate)* membership in the Poquetanuck Fire Department.

Name in Full _____

Date of Birth _____Social Security #_____Marital Status_____

Present Address_____

Phone #_____Length of time in Preston_____

Ct Driver's License #_____Class#_____

Family / Medical Physician_____Phone#_____

Medical / Physical disabilities? NoYes If yes, please explain._____

_____

Have you ever been a Fireman?No Yes If yes, where?_____

Fire training / experience (*please list.)*_____

_____

CPR_____EMT_____MRT_____Other_____

(Please give certification number and Expiration Date.)

Have you ever been dismissed by this or any other commission, service or department? NoYes

If yes, reason_____

Present employer and occupation_____Emp. Phone#_____

List last two(2) employers_____

_____

Have you ever been convicted of a felony? No Yes If yes, please explain._____

Applicant's Signature_____ Sponsor's Signature_____

Date_____

Proposer's Signature_____

Proposer's Signature_____

Proposer's Signature_____

_____

FOR OFFICIAL USE ONLY

Accepted / Rejected

Date of Application _____ Date Sworn In_____

Verified By_____ Title_____

Date to Review Probation Period_____ Active__Associate__Dismiss__Date_____

AUTHORIZATION

TO: Any physcian, nurse or other medical facility providing medical care, treatment or services, or Alcohol and / or Drug Abuse Treatment.

TO: Any Fire Department or Ambulance Service.

TO: Any Local or State Police Department.

TO: Each Employer of the individual identified below.

I hereby authorize the Investigating Committee of The Poquetanuck Fire Department to obtain all records of any nature, including medical records, Fire Department and Ambulance Service records from which i belong to in the past or present, Police records past or present, and Personnel records from past and present employers.

Upon presentation of this authorization, or a photocopy thereof, said representative may review such records and obtain exact copies thereof.

This authorization does not expire until expressly withdrawn by the undersigned.

Date:_____

Applicant's Signature_____ Social Security #_____

Witnessed by Sponsor_____