BOZRAH VOLUNTEER FIRE CO., INC

239 Fitchville Road – PO Box 2 - Bozrah, CT 06334
860-887-9474

APPLICATION FOR MEMBERSHIP

Applicant must live within a one (1) mile radius of the Bozrah town line. Upon acceptance, applicant must serve a probationary period of not less than three (3) months and not more than twelve (12) months. Upon successful completion of this period, applicant may then be accepted as an active member.

Last Name: _____ First Name: _____ Middle: _____

Date of Application: _____ Date of Birth: _____/_____/_____

Address:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____ Social Security #: _____

Driver's License: State: _____ Number: _____ Type/Class: _____ Exp.: ____/____/____

Motor Vehicle Convictions in the Past Three Years: _____

Have you ever been convicted of a felony? (If Yes, give details below) YES NO

_____

Have you ever been a member of any other Fire Company? (If yes, list departments and positions below)

YES NO _____

All applications shall be assessed at a fee of $5.00. Fee must accompany this application. (Fee will be refunded if applicant is initially rejected.) *Also accompanying this application must be a signed physician's form stating applicant has no history of hypertension or heart disease.*

I, the undersigned, on acceptance will abide by all rules, regulations and bylaws of the Bozrah Volunteer Fire Company, Inc. I also certify the information I provided on this application to be true and authorize any criminal background check that may be conducted by the fire company.

Applicant's Signature: _____ Date: _____

Office Use Only: Accepted _____ Rejected _____ Date _____ Recommended By: _____

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Phone: 860-887-9474 • Fax: 860-887-8819
www.bozrahfire.org

FIREFIGHTER MEDICAL CLEARANCE FORM

This form must be filled out and signed by your primary physician and returned with your application for Membership.

Name of Applicant: _____

Date of Birth: _____

Firefighter Statement (Filled out by Applicant)

I intended to perform the following duties: (Check all that apply)

Respirator/SCBA use	❑ Yes	❑ No
Interior Firefighting	❑ Yes	❑ No
Fire Ground Support	❑ Yes	❑ No
Fire Police	❑ Yes	❑ No
Fire Apparatus Operator	❑ Yes	❑ No
EMT/MRT	❑ Yes	❑ No

Physician/Examiner Statement

I have examined the above firefighter applicant on _____ and I am familiar with OSHA Standard 29CFR 1910.134. Based on the results of that exam, it is my opinion the above firefighter applicant is cleared for the following:

Respirator/SCBA use	❑ Yes	❑ No
Specific Limitations: _____		
Follow-Up Evaluation: _____		
Interior Firefighting	❑ Yes	❑ No
Fire Ground Support	❑ Yes	❑ No
Fire Police	❑ Yes	❑ No
Fire Apparatus Operator	❑ Yes	❑ No
EMT/MRT	❑ Yes	❑ No

Physician Name: _____ Date: _____

Physician Signature: _____

Name of Practice: _____ Phone #: _____

Medical Examiner's Lic. or Cert. #: _____ Issuing ST: _____ Exp. Date: _____