DEER MOUNTAIN FIRE PROTECTION DISTRICT VOLUNTEER APPLICATION **Date Joined:**_____

PERSONAL INFORMATION

NAME DATE OF BIRTH

ADDRESS

EMAIL PHONE (home) (cell)

EMERGENCY CONTACT NAME PHONE (home) (cell) ADDRESS (if different than above)

SOCIAL SECURITY NO DRIVER'S LICENSE NO & STATE

HEIGHT WEIGHT HAIR COLOR EYE COLOR

FIRE/EMS TRAINING (Fire Dept, schooling, certs, etc.–Skip this section if completing ROSS Personnel form for National Fire Fighting)

(TRAINING/CERTS CONTINUED)

FIRE/EMS EXPERIENCE (Skip this section if completing ROSS Personnel form for National Fire Fighting)

(FIRE/EMS EXPERIENCE CONTINUED)

STATUS OF PHYSICAL FITNESS: After reading the attached "ESSENTIAL FIRE FIGHTING FUNCTIONS" do you have any physical disability or medical condition that would limit your capacity to fight fires or provide EMS Service [ ]Yes [ ]No

Are you on disability or disabled? [ ]Yes [ ]No If yes to either of these questions ,please explain:

Would you submit to a medical-physical examination or drug test upon request by chief or medical manager? [ ]Yes [ ]No

BENEFICIARY(S) - List names, relation, addresses and phone numbers and percentage

NAME/RELATIONSHIP	ADDRESS	PHONE	PERCENTAGE
NAME/RELATIONSHIP	ADDRESS	PHONE	PERCENTAGE
NAME/RELATIONSHIP	ADDRESS	PHONE	PERCENTAGE
NAME/RELATIONSHIP	ADDRESS	PHONE	PERCENTAGE
NAME/RELATIONSHIP	ADDRESS	PHONE	PERCENTAGE

I understand that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and violation could result in termination. By signing this application i (1) agree to abide by the above statement and (2) agree to notify Chief and/or EMS manager in writing with in 5 calendar days if I am convicted for a violation of a criminal drug statute occurring in the workplace.

I, the undersigned, have read and fully accept the Deer Mountain Volunteer Fire Department By-Laws as they stand. I fully accept the rights, privileges and responsibilities held by these By-Laws

I hereby agree that the above information in this application is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Witness (print name):_____

Witness (signature): _____ Date: _____

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

Required Attachments: (1) Photo copy of Driver's license or Colorado ID (2) current vehicle registration/insurance card
(3) Authorization for Release of Information (4) Confidentiality Agreement.
(5) Worker's Compensation Preferred Providers form (6) Medical Statement
(7) ROSS Personnel Form, if you are interested in going on National Fires

ESSENTIAL FIRE FIGHTING FUNCTIONS

These essential functions are what fire fighters are expected to perform at emergency incidents and are derived from NFPA 1001.

1. Operate both as a member of a team and independently at incidents of uncertain duration.
2. Spend extensive time outside exposed to the elements.
3. Tolerate extreme fluctuations in temperature while performing duties. Must perform physically demanding work in hot (up to 400 degrees F). humid (up to 100) atmospheres while wearing equipment that significantly impairs body-cooling mechanisms.
4. Experience frequent transitions from hot to cold and from humid to dry atmospheres.
5. Work in wet. icy. or muddy areas.
6. Perform a variety of tasks on slippery, hazardous surfaces such as rooftops or from ladders.
7. Work in areas where sustaining traumatic or thermal injuries is possible.
8. Face exposure to carcinogenic dusts such as asbestos. toxic substances such as hydrogen cyanide. acids. carbon monoxide, or organic solvents either through inhalation or skin contact.
9. Face exposure to infectious agents such as hepatitis B or HIV.
10. Wear personal protective equipment that weighs approximately 50 pounds while performing fire fighting tasks.
11. Perform physically demanding work while wearing posttlve pressure breathing equipment with 1.5 inches of water column resistance to exhalation at a flow of 40 liters per minute.
12. Perform complex tasks during life-threatening emergencies.
13. Work for long periods of time. requiring sustained physical activity and intense concentration.
14. Face life or death decisions during emergency conditions.
15. Be exposed to grotesque sights and smells associated with major trauma and burn victims.
16. Make rapid transitions from rest to near maximal exertion without warm-up periods.
17. Operate in environments of high noise, poor visibility, limited mobility, at heights, and in enclosed or confined spaces.
18. Use manual and power tools in the performances of duties.
19. Rely on senses of Sight, touch, hearing, and smell to help determine the nature of the emergency. Maintain personal safety, and make critical decisions in a confused, chaotic, and potentially life-threatening environment through-out the duration of the operation.
20. Operate motor vehicle in full compliance with Colorado Law.

DEER MOUNTAIN FIRE PROTECTION DISTRICT

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the designated officer of Deer Mountain Fire Protection District to conduct a background investigation for the purpose of verifying the information contained in my application, the status of my driver's license and driving record and any criminal convictions on my record.

I specifically authorize any person, firm or corporation contacted by the designated officer of Deer Mountain Fire Protection District to release any of the above records.

THIS IS NOT AN AUTHORIZATION FOR THE RELEASE OF SOCIAL SECURITY NUMBER TO ANYONE, AND/OR ANY ORGANIZATION.

Full Name Printed: _____

Address: _____

Social Security Number: _____
(Optional for identification verification only.)

Date of Birth: _____ Race: _____ Gender: _____

Signature: _____ Date: _____

Witness (print name): _____

Witness (signature): _____ Date: _____

Deer Mountain Fire Protection District Confidentiality Agreement

As a volunteer for the Deer Mountain Fire Protection District (DMFPD) you help people in their most vulnerable time; and many times they are in an embarrassing or stressful situation. These events tend to make individuals not be fully aware of what may be occurring around them. They may say, do or react to things in a behavior outside their normal way of responding.

While you are involved with DMFPD as a firefighter, EMS personnel, rescue personnel and/or assisting with a medical emergency there may be times that you discover private/personal information about the individual or individuals involved in the situation. It is imperative that you display the utmost professionalism and confidentiality surrounding these events. The information that you may learn may involve their private/personal life. Just as you would not want your personal information shared throughout the community, neither do those that DMFPD serve. I the information learned is pertinent to the situation and the care to be given then it should be shared with the appropriate personnel. Any information obtained should not be discussed among yourselves outside the department or with others not involved with the incident. For those involved in stressful situations it may be necessary to debrief after an intense call. Be aware of those in your immediate area, volume and intensity of your voice, slang or terminology that may be used and the situations that you may be discussing. The use of names, addresses and other identifying information (i.e. license plate numbers) should be avoided.

Any discussion during or after the event of this situation could be become embarrassing, stressful and/or degrading to the individuals involved, as well as to the DMFPD community. If needed, information may be providec upon request by law enforcement personnel and/or by a court of law. If the information obtained is questionable or out of the anticipated nature of the call the information needs to be reported to Incident Command and/or officers of DMFPD.

Upon signing this agreement you are bound by the By-Laws of Deer Mountain Volunteer Fire Department (DMVFD) for verbal or written reprimand and the procedures described therein. If a breach of confidentiality occurs the Officers of DMVFD will rely on the By-Laws to reprimand all individuals involved in the breach.

The original signed copy of this document will be retained in your personnel file.

Printed Name:_____

Signature:_____ Date:_____

Deer Mountain Fire Protection District

6181 County Rd 28••Texas Creek, C0 81223••719.942.9610

To: All Employees and Volunteers

From: Deer Mountain Fire Protection District

Date: December 15, 2016

Subject: Designated Medical Providers for Work-Related Injuries and Illnesses

Effective January 1, 2017 all employees must obtain treatment of work-related injuries and illnesses from one of the following medical providers:

1. Salida Family Medicine - 20180 Highway 50, Suite C, Cotopaxi, CO 81223 / 719-539-3612
2. 1st Street Family Health – 910 Rush Drive, Salida, CO 81201 / 719-539-6637
3. Salida Family Medicine – 320 E 1st Street, Salida, CO 81201 / 719-539-3583
4. St. Thomas Moore – 1338 Phay Avenue, Canon City, CO 81212 / 719-269-2000 Dr. Julian Venegas
5. CCOM Canon City – 3245 E Hwy 50 Ste E, Canon City, CO 81212 / 719-285-2800 Dr. Nanes DO, Dr. Quakenbush PA

In the event of a life- or limb-threatening emergency, the injured employee will be sent to the nearest emergency medical facility. One of the medical providers designated above must provide all follow-up care.

If an unauthorized medical provider treats an employee, the employee will be responsible for payment for said treatment.

I have read and am fully aware of the organization's policy regarding medical treatment for work-related injuries and illnesses. I further understand that I must immediately report any work-related injury to my supervisor.

All employees must sign below, acknowledging this policy.

_____

Employee's name (Print)

_____ _____

Employee's signature **Date**

VFIS
A Division of Glatfelter Insurance Group

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: _____

		Yes	No
2. **Eyesight:**			
a. Have you lost use of either eye? _____ R _____ L	a.	☐	☐
b. Is peripheral (side) vision restricted?	b.	☐	☐
c. Are you color blind?	c.	☐	☐
d. Do you have, or have you ever had, cataracts?	d.	☐	☐
e. Are actual deficiencies corrected by glasses or contact lenses?	e.	☐	☐
f. Date of last eye examination:	f.	_____	
3. **Hearing:**			
a. Do you have difficulty hearing normal conversation level?	a.	☐	☐
b. Do you use a hearing aid?	b.	☐	☐
4. **Diabetes:**			
a. Have you ever been treated for diabetes?	a.	☐	☐
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.	☐	☐
b. Describe condition:	b.	_____	
c. Describe current medication and dosage, if any, under "remarks."			
d. Do you have a pacemaker?	d.	☐	☐
e. Date of last treatment or check-up:	e.	_____	
6. **Epilepsy:**			
a. Have you ever been treated for epilepsy?	a.	☐	☐
b. If "Yes," when was your last seizure?	b.	_____	
c. Describe current medication and dosage, if any, under "remarks."			

Questions:

		Yes	No
7. Blood Pressure:			
a. Have you ever been treated for high blood pressure?	a.	☐	☐
b. If "Yes," when were you treated?	b.	_____	
c. What was your last reading?	c.	_____	
d. Describe current medication and dosage, if any, under "remarks."			
8. Limbs:			
a. Have you lost an arm or leg?	a.	☐	☐
b. Have you lost the use of an arm or leg?	b.	☐	☐
c. Does vehicle have special controls?	c.	☐	☐
d. If "Yes" to any of the above, describe under "remarks."			
9. Miscellaneous:			
a. Have you ever had, or been treated for, Convulsions?	a.	☐	☐
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?	c.	☐	☐
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?	e.	☐	☐
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?	g.	☐	☐
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?	i.	☐	☐
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:** _____

REMARKS:

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**

NEW ROSS Personnel

(Only Required if you are interested in going on National Fires)

Name _____

Address _____

Phone _____

Email _____

Emergency contact:

Name _____

Relationship _____

Address _____

Phone _____

Height (inches) _____

Weight _____

List past training and experiences with dates, location, position held, trainer/instructor

_____

_____

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