

**PEMBERTON TOWNSHIP VOLUNTEER EMERGENCY SERVICES
APPLICATION FOR MEMBERSHIP**

Organization: **Country Lakes Fire Company, Station 183**

(Print or write all information, all spaces must be completed)

Application for: Firefighter Jr. Firefighter Contributing Auxiliary

Name: _____ Date: ___/___/___
(Print your name as it appears on your driver's license)

Home Address: _____

Previous Address: _____
(If less than 3 years at current Address)

Date of Birth: ___/___/___ Phone #: _____

Resident Since: ___/___/___ SSN: _____ - _____ - _____

DL #: _____ State: _____

Occupation: _____ Employer: _____

In Case Of Emergency, NOTIFY: _____ Phone : _____

Previous Member in another Company? _____ Yes _____ No

Former Company: _____

Current Membership in another Company? _____ Yes _____ No

Company: _____

Any Criminal Convictions? _____ Yes _____ No In New Jersey? _____ Yes _____ No

Age: _____ Height: _____ Weight: _____ Hair: _____ Eyes: _____ Blood Type: _____

*****FIREFIGHTER APPLICANTS ONLY COMPLETE THE FOLLOWING*****

*Training/Experience: (Provide Certificates if available)

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* Were you in the New Jersey State relief Association? _____ Yes _____ No

- If Yes: In Quota? _____ Yes _____ No Line # : _____ Time: _____ Assoc: _____

*******RECORDS CHECK AUTHORIZATION*******

Note: All applicants by virtue of their signature agree and permit a check of records of former Fire Company, Police, State and/or Federal Agency files. False statements and/or derogatory information are cause for dismissal.

Applicants for Firefighter must have a physician's certificate of fitness for duty prior to acceptance as a Firefighter.

Signature: _____ Parent Or Guardian Signature _____
(If Under 18)

FOR COMPANY USE ONLY

Approval of Membership Committee _____ Date: ___/___/___

Records Check:

Remarks: _____

Date: ___/___/___

FOR TOWNSHIP USE ONLY

Approved by Township Clerk: _____

Date: ___/___/___

MARY ANN YOUNG, CMC, TOWNSHIP CLERK

PHYSICAL TEST RECORD

To be completed by a practicing Physician in the State of New Jersey
(print or type all information)

Name: _____

Age: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Eyesight: _____ Hearing: _____ Blood Pressure: _____ / _____

Has applicant any apparent disabilities in:

Heart: _____

Lungs: _____

Joints: _____

Veins: _____

Feet and Legs: _____ Hands and Arms: _____

Spine: _____

Hernia: _____

Has applicant ever suffered from dizzy or fainting spells? _____ Yes _____ No

If yes, describe _____

Has applicant ever suffered from injury? _____ Yes _____ No If yes, when? _____

If yes, describe? _____

Excessive use of narcotics, drugs or alcohol? _____ Yes _____ No

If yes, describe _____

I hear-by certify that as a practicing Physician in the State of New Jersey, the applicant is free from any acute or chronic disease and has no physical defects.

Rejection is based on the following:

Date Examined: ____/____/____

Examined at: _____

(Address of Office)

(Signature of Physician)