



NORTH SPARTANBURG FIRE and EMERGENCY SERVICES DISTRICT

All information and references given on the application may be verified by the Fire District.

Name: _____ Date: _____

Address: _____ Phone 1: _____

City, State, Zip: _____ Phone 2: _____

Date of Birth: _____ S.S. #: _____

Drivers License Number: _____ Class: _____

Drivers License State: _____ Drivers License Expiration Date: _____

Current Employment or Name of School: _____

Email Address: _____

Why do you wish to become a part of this organization?

Employment Applying for:

- Full Time
- Part Time
- Volunteer section applying for: (please check one) see attached instructions
 - Fire Fighter – Fire Fighting, Rescue, Medical Response
 - Service - Fireground Rehab, Training Rehab, Fire Ground Support

Educational Background:

High School/Tech School: _____

College/Vocational School: _____

Post Graduate: _____

Military Experience: _____

Previous Firefighting/EMS Experience:

Fire Department/EMS Name: _____ Date: _____ Rank: _____

Fire Chief's/Administrator's Name: _____ Phone #: _____

Total years involved in above: _____

List Any Other References: _____

Fire Schools/Training [Firefighters/Rescue, EMS, etc.]

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Health Information:

Is there any reason that your present health condition would restrict your activities as a firefighter/emergency service provider? [If yes, please explain.]

Do you suffer from any fear/phobias that would restrict your activities as a firefighter/emergency service provider? [fear of height, claustrophobia, etc.]

Name of Person to contact in case of an emergency: _____

Emergency Phone Numbers: ____ () ____ () _____

Beneficiary: _____ Relationship: _____

Background Investigation:

Have you ever been convicted of a crime? Yes No
[If yes, please explain]

Note: Complete SC SLED Request for Criminal Record Review (*attached*)
Complete Fire District Medical Statement (*attached*)

**** The applicant certifies that the above information is true and accurate.***

Signature of Applicant: _____ Date: _____

Date applicant accepted by the Fire District: _____

All Fire Fighter applicants must read and be able to comply with the following:

- Be physically able to perform fire fighter duties
 - Wear protective clothing
 - Climb ladders
 - Pull fire hose
 - Wear Self Contained Breathing Apparatus
- Attend Monday night drills and other training classes
- Complete an Interior Fire Fighting class within one (1) year of employed date
- Complete a First Responder class within one (1) year of employed date
- Attend annual Infection Control classes
- Have TB test performed annually
- Take and pass a medical evaluation to perform fire fighter duties
- Take and pass a medical evaluation to wear a respirator.
- Have Hepatitis shots up to date

All Service applicants must read and be able to comply with the following:

- Attend Monday night drills and other training classes
- Attend annual Infection Control class
- Have TB test performed annually
- Have Hepatitis shots up to date
- Complete a First Responder class within one (1) year of employed date
- Take and complete an emergency vehicle driving class before driving any Fire District vehicle.

Application Directions:

- Fill out entire application
- Fill out and sign the Request for Criminal Record Review form
- Make sure you sign and date the application
- Deliver the package to the Headquarters Station 8767 Asheville Highway
- You will be contacted to schedule an interview

Information You Should Know:

- You will be placed on a probation period of up to six (6) months.
- You are expected to train and educate yourself in Fire and Medical service.
- You are expected to answer emergency calls by the guidelines of the Fire District.
- You are expected to work with other employees as part of the team.
- You are expected to be professional in you duties and actions.
- The Fire District will furnish and issue the equipment you need.
- Do not purchase any equipment on your own.

South Carolina Firefighter Registration Act
Request for Criminal Record Review

Name: _____ (Full Given Name)

Address: _____

City State Zip

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____

Driver's License: State _____ Number _____

Race: _____ Sex: Male Female

I, _____ do hereby grant approval for the
(Print Name)

North Spartanburg Fire and Emergency Services District to inquire and receive any
and all criminal information
pertaining to me.

Applicant Signature

Date

Authorized Signature

Date

Mail Request To:
S.L.E.D. Records
P.O. Box 21398
Columbia, SC 29221-1398
Phone: 1-803-737-9000
Fax: 1-803-896-7022

S.L.E.D. Should
Return Information To:
Fire Chief
North Spartanburg Fire District
8767 Asheville Highway
Spartanburg, SC 29316-4609

Reports should be returned
to the Fire Department – Not
to the Fire Marshal's Office.

*Note to Fire Departments:
Please include a self-addressed
envelope for return of report
from S.L.E.D.



NORTH SPARTANBURG FIRE DISTRICT Medical Statement of Personnel

Name: _____

Address: _____

City, State, Zip: _____

Occupation: _____

Position/Title: _____

Social Security Number: _____ - _____ - _____

Drivers License Number: _____ Class: _____

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: _____

2. Eyesight:

- | | Yes | No |
|---|-----------------------------|--------------------------|
| a. Have you lost use of either eye? R _____ L _____ | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is peripheral (side) vision restricted?..... | b. <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you color blind? | c. <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have, or have you ever had, cataracts? | d. <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are actual deficiencies corrected by glasses or contact lenses?... | e. <input type="checkbox"/> | <input type="checkbox"/> |
| f. Date of last eye examination:..... | f. _____ | |

3. Hearing:

- | | | |
|---|-----------------------------|--------------------------|
| a. Do you have difficulty hearing normal conversation level?..... | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you use a hearing aid? | b. <input type="checkbox"/> | <input type="checkbox"/> |

4. Diabetes:

- | | | |
|--|-----------------------------|--------------------------|
| a. Have you ever been treated for diabetes? | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe current medication and dosage, if any, and method of administration under "remarks." | b. <input type="checkbox"/> | <input type="checkbox"/> |
| c. Date of latest blood sugar test: | c. _____ | |

5. Heart:

- | | | |
|---|-----------------------------|--------------------------|
| a. Have you ever been treated for heart disease? | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe condition:..... | b. _____ | |
| c. Describe current medication and dosage, if any, under "remarks." | c. <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have a pacemaker? | d. <input type="checkbox"/> | <input type="checkbox"/> |
| e. Date of last treatment or check-up: | e. _____ | |

6. Epilepsy:

- | | | |
|---|-----------------------------|--------------------------|
| a. Have you ever been treated for epilepsy?..... | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when was your last seizure?..... | b. _____ | |
| c. Describe current medication and dosage, if any, under "remarks." | | |

7. Blood Pressure: Yes No

- | | | |
|---|-----------------------------|--------------------------|
| a. Have you ever been treated for high blood pressure? | a. <input type="checkbox"/> | <input type="checkbox"/> |
| 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." | | |

Continued on next page

8. Limbs:

- a. Have you lost an arm or leg?
- b. Have you lost the use of an arm or leg?.....
- c. Does vehicle have special controls?
- d. If "Yes" to any of the above, describe under "remarks."

	Yes	No
a.	<input type="checkbox"/>	<input type="checkbox"/>
b.	<input type="checkbox"/>	<input type="checkbox"/>
c.	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS:

9. Miscellaneous:

- a. Have you ever had, or been treated for, Convulsions?
- 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?.....
- 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?.....
- 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?
- 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?
- j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks."

a.	<input type="checkbox"/>	<input type="checkbox"/>
c.	<input type="checkbox"/>	<input type="checkbox"/>
e.	<input type="checkbox"/>	<input type="checkbox"/>
g.	<input type="checkbox"/>	<input type="checkbox"/>
i.	<input type="checkbox"/>	<input type="checkbox"/>

10. What is the date of your last physical examination? _____

11. Are there any restrictions posted on your driver'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: _____

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 North Spartanburg Fire and Emergency Services District 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