Steps to Membership:

- Complete Application with Fire Department (FD) representative
- Application is presented to FD at the next meeting we encourage the applicant to be present at the meeting
- Application is tabled for 30 days for review by the FD membership committee for recommendation.
- We encourage applicants to show up for drills & events for 30 days to become familiar with members and the operations.
- A physical/ fit test and drug screening are required and should be obtained at this time. See the membership committee asap for physical paperwork, a mask, and to make an appointment.
- FD membership votes on the applicant. The applicant may **NOT** be present for this meeting
- The applicant will be notified of membership status by the membership committee on the night of the meeting.
- Board of Fire Commissioners (BOFC) will review the application at their next meeting (if paperwork is provided) and determine active firefighter status. Members will be notified by the membership committee of your status, followed by information and a welcome letter from the Fire District.
- **Sexual Harassment training MUST be completed within 2-weeks of acceptance by the BOFC and every year-to-date of the first training as mandated by the State of New York.**
    - **See BOFC secretary**
- Once approved by BOFC, the applicant will be issued turn-out gear, pager and *** If you are 18yrs of age**, a key and membership/ blue light card will be issued by the Chief
- At this point you will be allowed to participate in drills and attend calls.
- The 6-month probationary criteria in the fire department By-Laws must be met.
- After completing the 6-month probation period you will be issued an FD badge, t-shirt, and hat, plus authorized to be fitted for uniforms.
- Within the first 2 years of membership applicant must complete Basic Exterior Fire Operations (BEFO) and/or Fire Police training to fulfill requirements for new members.
- Annual Osha & Pesh standards including the Best Practices training (as adopted by NYS), must be completed yearly to remain active (once you have completed your initial required training).

Benefits Provided:

- Workmen's Compensation, Accident, Cancer, and Life Insurance; firefighters are also covered under New York State Volunteer Firemen's Benefit Law.
- If Service Award Program requirements are met, an annual deposit of $1,200 is deposited into a fund to be collected at age 60.
- All approved training provided at no cost.
- Gym membership reimbursement of up to $20 per month when requirements of 4 (four) visits a month, are met. (Turn in to the District Secretary)
- Personal fire-fighting equipment assigned: coat, bunkers, boots, gloves, helmet, and pager
- Employee Assistance Program provided by the Fire District.

OSHA® FactSheet

Hepatitis B Vaccination Protection

Hepatitis B virus (HBV) is a pathogenic microorganism that can cause potentially life-threatening disease in humans. HBV infection is transmitted through exposure to blood and other potentially infectious materials (OPIM), as defined in the OSHA Bloodborne Pathogens standard, 29 CFR 1910.1030.

Any workers who have reasonably anticipated contact with blood or OPIM during performance of their jobs are considered to have occupational exposure and to be at risk of being infected. Workers infected with HBV face a risk for liver ailments which can be fatal, including cirrhosis of the liver and primary liver cancer. A small percentage of adults who get hepatitis B never fully recover and remain chronically infected. In addition, infected individuals can spread the virus to others through contact with their blood and other body fluids.

An employer must develop an exposure control plan and implement use of universal precautions and control measures, such as engineering controls, work practice controls, and personal protective equipment to protect all workers with occupational exposure. In addition, employers must make hepatitis B vaccination available to these workers. Hepatitis B vaccination is recognized as an effective defense against HBV infection.

HBV Vaccination

The standard requires employers to offer the vaccination series to all workers who have occupational exposure. Examples of workers who may have occupational exposure include, but are not limited to, healthcare workers, emergency responders, morticians, first-aid personnel, correctional officers and laundry workers in hospitals and commercial laundries that service healthcare or public safety institutions. The vaccine and vaccination must be offered at no cost to the worker and at a reasonable time and place.

The hepatitis B vaccination is a non-infectious, vaccine prepared from recombinant yeast cultures, rather than human blood or plasma. There is no risk of contamination from other bloodborne pathogens nor is there any chance of developing HBV from the vaccine.

The vaccine must be administered according to the recommendations of the U.S. Public Health Service (USPHS) current at the time the procedure takes place. To ensure immunity, it is important for individuals to complete the entire course of vaccination contained in the USPHS recommendations.

The great majority of those vaccinated will develop immunity to the hepatitis B virus. The vaccine causes no harm to those who are already immune or to those who may be HBV carriers. Although workers may desire to have their blood tested for antibodies to see if vaccination is needed, employers cannot make such screening a condition of receiving vaccination and employers are not required to provide prescreening.

Employers must ensure that all occupationally exposed workers are trained about the vaccine and vaccination, including efficacy, safety, method of administration, and the benefits of vaccination. They also must be informed that the vaccine and vaccination are offered at no cost to the worker. The vaccination must be offered after the worker is trained and within 10 days of initial assignment to a job where there is occupational exposure, unless the worker has previously received the vaccine series, antibody testing has revealed that the worker is immune, or the vaccine is contraindicated for medical reasons. The employer must obtain a written opinion from the licensed healthcare professional within 15 days of the completion of the evaluation for vaccination. This written opinion is limited to whether hepatitis B vaccination is indicated for the worker and if the worker has received the vaccination.

Declining the Vaccination

Employers must ensure that workers who decline vaccination sign a declination form. The purpose of this is to encourage greater participation in the vaccination program by stating that a worker declining the vaccination remains at risk of acquiring hepatitis B. The form also states that if a worker initially declines to receive the vaccine, but at a later date decides to accept it, the employer is required to make it available, at no cost, provided the worker is still occupationally exposed.

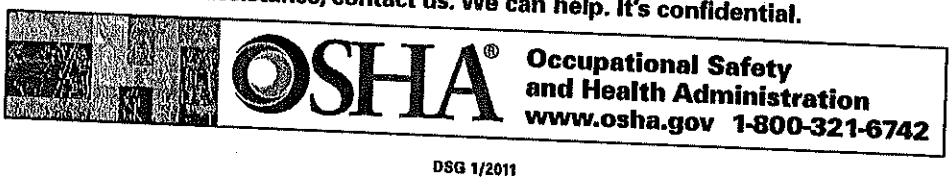
Additional Information

For more information, go to OSHA's Bloodborne Pathogens and Needlestick Prevention Safety and Health Topics web page at: https://www.osha.gov/SLTC/bloodbornepathogens/index.html.

To file a complaint by phone, report an emergency, or get OSHA advice, assistance, or products, contact your nearest OSHA office under the "U.S. Department of Labor" listing in your phone book, or call us toll-free at (800) 321-OSHA (6742).

This is one in a series of informational fact sheets highlighting OSHA programs, policies or standards. It does not impose any new compliance requirements. For a comprehensive list of compliance requirements of OSHA standards or regulations, refer to Title 29 of the Code of Federal Regulations. This information will be made available to sensory-impaired individuals upon request. The voice phone is (202) 693-1999; teletypewriter (TTY) number: (877) 889-5627.

For assistance, contact us. We can help. It's confidential.



DSG 1/2011

Revised SEP 2022

APPLICATION FOR VOLUNTEER MEMBERSHIP
into the ROCK CITY FALLS VFD aka Milton Eagles VFD
of Milton Fire District NO.1

I HAVE RECEIVED:

Acknowledgment – return
Out of District Form – return (if applicable)
Parental Consent Form – return **Notarized** or signed by the commissioner **(minors only)**
Alcohol/Drug Screening Consent – mandatory (return)
Hepatitis B Vaccine Form – Consent ***OR*** Declination – return
Provident Beneficiary Form – return
Service Award Program Beneficiary Form – return
VFIS Beneficiary Form – return
Service Award Beneficiary Designation ***OR*** Declination Form – return
Alcohol & Drug Policy including AEP Benefits – keep
Blue Light Policy – keep
OSHA Infection Control Standards – keep
OSHA Hep B Vaccine Facts – keep
Sexual Harassment Policy – keep
Fire Districts Rules & Regulations – keep
Fire Districts Policies & Procedures – keep
Fire Departments Standard Operating Guidelines (SOG) – keep

I have received, read, understand, agree to follow, and adhere to all the information provided in this packet. I asked questions about anything that I did not understand, and those questions were answered to my satisfaction.

_____
Applicant's Name **(Print)**

_____ _____
Applicant's Signature Date

_____ _____
Membership Committee Signature Date

- Alcohol/Drug Screening Test is ***MANDATORY*** – If you decline testing, application for membership should not be completed.
- After being voted in by the Fire Department, a physical ***MUST BE*** completed ASAP. Board of Fire Commissioners will not review applications submitted without proof of a completed physical.
- Sexual Harassment training **MUST** be completed within 2 weeks of the BOFC approval; proof from your employer of the previous completion will be accepted.

Milton Eagles VFD aka Rock City Falls VFD
PO Box 25
1119 Rock City Road
Rock City Falls, NY 12863
Phone (518) 885-7694 Fax (518) 885-6333

APPLICATION FOR VOLUNTEER FIREFIGHTER

Qualified applicants are considered without regard to race, color, creed, sex, national origin, age, marital or veteran status.

Name _____
(last) (first) (middle)

Address _____ **ZIP Code** _____

Date of Application _____ **SS #** _____

Place of Birth: City _____ **State** ____

Home Phone # _____ **Are you over 18?** yes/no **If no State your Age** _____

Cell Phone # _____ **Cell Provider** _____

Email Address _____

Emergency Contacts _____
(name & number)

Blood Type _____ **Height** _____ **Weight** _____ **Eye Color** _____ **Hair Color** _____

Have you previously filed an application with this organization? ( ) Yes ( ) No
Have you any previous firefighting experience? ( ) Yes ( ) No
Are you a citizen of the United States? ( ) Yes ( ) No
If not, do you possess an Alien Registration Card? ( ) Yes ( ) No
Do you have any friends or relatives who are presently members of this organization? ( ) Yes ( ) No

If yes, list name(s)

_____

_____

Have you ever been convicted of a misdemeanor or felony? ( ) Yes ( ) No
Have you ever been convicted of an arson-related crime? ( ) Yes ( ) No
Are you a veteran of the United States Military Service? ( ) Yes ( ) No

Do you have any physical, mental or medical impairment or disability that would limit your job performance? ( ) Yes ( ) No ( ) Maybe

If necessary, please explain

_____

_____

Are you presently a member of any other civic organization? ( ) Yes ( ) No

If Yes, please list _____

Please give name, address and telephone number for three (3) references, not related to you

_____

_____

_____

Education Years Completed _____ Diploma/Degree _____

Specialized training, skills _____

_____

Employment

List current place of employment

Name _____ phone _____

address _____

Name _____ phone _____

address _____

Driver Information

Driver License Number _____ State license issued _____

Availability for Membership

Please indicate your availability to participate in normal required fire department activities such as meetings (2nd Tues of month), drills (Wed mornings & Thurs Evenings), and emergency calls. Please check appropriate time periods:

Weekdays: Days _____ Evenings _____ Nights _____

Weekends: Days _____ Evenings _____ Nights _____

I also acknowledge that my placement within Milton Fire District No. 1, depends on the outcome of an OSHA mandated physical examination to be completed and submitted to the Board of Fire Commissioners at the same time as application for membership. YES _____ NO _____

ADDITIONAL INFORMATION

_____

_____

_____

WITHIN THE FREEDON OF INFORMATION LAW, ALL INFORMATION CONTAINED OR OBTAINED HERIN WILL REMAIN CONFIDENTIAL AND WILL BE USED ONLY FOR INTERNAL MEMBERSHIP PROCESSING.

IN WITNESS WHEREOF, this application has been submitted this _____ day of _____, 20_____,

by the undersigned applicant who affirms that the statements herein are true under penalties of perjury.

Applicant's Signature: _____

Date: _____

Witnessed by Membership Committee: _____

Date: _____

Consent For Disclosure

I, _____ *give the Investigating Officer of the Milton Eagle's Volunteer Fire Department my consent to make inquiries of my employers, neighbors, police agencies and insurance carrier while conducting an investigation of my character, past record and responsibility.*

Signature of Applicant _____ Date _____

Signature of Membership Committee _____ Date _____

Comments of Investigating Officer:

_____

_____

_____

MILTON FIRE DISTRICT NO. 1
P. O. BOX 72
ROCK CITY FALLS, NY 12863
PHONE: (518)885-7694 FAX: (518) 885-6333

ADOPTED BY THE BOARD OF FIRE COMMISSIONERS OF MILTON FIRE DISTRICT NO. 1 AS OF JULY 5, 2005

NEW MEMBER AS OF JULY 5, 2005

It is the policy of the Milton Fire District#1 to provide drug/alcohol screening for Persons elected to active membership with the Milton Eagles Volunteer Fire Department.

All applicants for membership with the Milton Eagles Volunteer Fire Department shall be required to sign a drug/alcohol test consent agreement. Failure to sign the consent and/or submit to testing shall disqualify the candidate for consideration for membership in the Fire Department.

In order to assist in meeting the goals of this policy, the Milton Fire District #1 shall take a pro-active approach to mitigate the problem of alcohol and/or drug addiction and abuse as outlined in the Alcohol & Drug Policy.

4.) Education

The Milton Fire District No.1 will make available brochures, flyers, and/or booklets on drug and alcohol abuse. This information, and/or information pertaining to the adverse results of drug and alcohol abuse, will be made available to the members through the Milton Fire District No.1, at least on an annual basis.

AS WELL STATED IN THE RULES AND REGULATIONS OF MILTON FIRE DISTRICT NO. 1: ARTICLE #23

#23 Membership requirements:

a. Appointment is conditional upon successful completion of OSHA mandated physical and alcohol/drug screening being submitted with the application of the new member to the Board...

I HEREBY AGREE TO THE ABOVE:
SIGNATURE OF APPLICANT

_____

CONSENT FOR HEPATITIS B VACCINE IMMUNIZATION *and* TITER

Hepatitis B Vaccine has proven to be successful in preventing Hepatitis B infection. Before making your decision to receive or not to receive this vaccine, please read and understand this form and the attached informational form relating to Hepatitis B and the vaccine. Please DO NOT sign this form until all your questions regarding this matter are answered.

1. The vaccine is given over a six-month period on ***three doses***: an initial injection, an injection one month later and an injection six months after the first injection.
2. In order to assure the best chance of full immunization, all three injections must be received.
3. The responsiveness of the vaccine is age dependent: seroconversion rates for 453 adults 20-39 years of age ranged from 95 to 99% and for 56 adults 40 years of age and older were 91%.

Please answer the following:	YES	NO
1. Are you pregnant?	_____	_____
2. Are you a nursing mother?	_____	_____
3. Do you have any immunodeficiencies?	_____	_____
4. Are you receiving any immunosuppressive therapy?	_____	_____
5. Have you had Hepatitis B?	_____	_____

I have read and understood all of the above information regarding Hepatitis B and the vaccine. I choose / do not choose to receive the vaccination.
It has also been explained to me that there is a rare chance that I may have immunity to the vaccine. In this case, I have been offered a blood test (TITER), to check my immunity after the series of vaccine. I choose / do not choose to have this blood test done.
I have been informed that if I fail to follow the recommended schedule the vaccine series may have to be restarted. In this case, I am aware that I will be responsible for payment of the vaccine and the administering thereof.

_____ _____

Signature Date

HEALTH CARE PROFESSIONALS HEPATITS B *DECLINATION* STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature Date

*Taken from: *Bloodborne Pathogens and Acute Care Facilities.* OSHA Publication 3128, (1992).

Adopted by the MFD NO.1
April 2, 2013

Milton Fire District #1
Request to Membership Continuation After Moving Out of District

MEMBER TO DEPARTMENT

I, _____ have moved out of district to the following address_____, New York _____. I am requesting continued membership in Rock City Falls Fire Department.

Members Signature_____ Date_____

We the Rock City Falls Fire Department **GRANT ( )** **DO NOT GRANT ( )** continued membership to the Rock City Falls Fire Department.

President of the Department Signature _____

Date_____

Department to District

We have received the above-mentioned request to continue membership after moving out of the district and request approval from the Board of Fire Commissioners.

We the Board of Fire Commissioners **GRANT ( )** **DO NOT GRANT ( )** continued membership in the Rock City Falls Fire Department.

Board of Fire Commissioners Signature _____

Date_____

Rev. 9/2022

MILTON FIRE DISTRICT NO.1
P.O. BOX 72
ROCK CITY FALLS, NY 12863
518-885-7694

PARENTAL CONSENT

I,_____, being the legal guardian and/or parent of

_____, do hereby give my consent for my son/daughter to become a member of the Milton Eagles Volunteer Fire Department aka Rock City Falls fire department (Group I). I give my consent for my son/daughter to:

Have an OSHA-mandated physical/fit test completed by MFD's physician

_____ YES _____ NO

Receive the Hepatitis B vaccine

_____ YES _____ NO

After the series of Hepatitis vaccines, have a blood test to check for antibodies

_____ YES _____ NO

I have been informed that having a physical completed is a requirement of membership to the Milton Eagles VFD aka Rock City Falls VFD. If I do not approve, my son/daughter will not become a member. I also understand that receiving the Hepatitis vaccine is not a requirement. I understand that due to occupational exposure to blood or other potentially infectious material, my son/daughter may be at risk of acquiring Hepatitis B Virus infection (HBV). I understand that the vaccine is offered at no charge to me and that by declining this vaccine, my son/daughter will continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future my son/daughter wants to be vaccinated with the Hepatitis B vaccine, he/she can receive the vaccination series at no charge to me.

_____ _____

Parental Signature Date Applicant Signature Date

_____

Witnessed by Notary or Fire Commissioner Date

Accident & Health Beneficiary Designation Form

Please complete this form and return it to your organization's Secretary who should maintain this form with your emergency service organization's records. Please do not return this form to Provident. If necessary, please photocopy this page or print additional copies at www.providentbenefits.com.
Please PRINT or TYPE.

Policyholder Name (Emergency Service Organization) _____ Policy # _____

Insured Person's Last Name _____ First _____ Initial _____ Date of Birth _____

Insured Person's Street Address _____

Insured Person's City _____ State _____ Zip Code _____ Social Security # _____

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Insured Person's Signature _____ Date Signed _____

PROVIDENT

PAL-AH-BENE 07/2006

Please return this form to your organization's secretary where it should be maintained with your emergency service organization's records.

Provided by: Provident Agency, Inc.
Toll Free 800.447.0360

VFIS®
A Division of Glatfelter Insurance Group

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800) 233-1957 or (717) 741-0911
www.vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐ _____ **Policyholder** _____ **Policy #** _____
☐ _____ **Policyholder** _____ **Policy #** _____
☐ _____ **Policyholder** _____ **Policy #** _____
☐ _____ **Policyholder** _____ **Policy #** _____
☐ **Other** _____
☐ **Other** _____

Last Name	**First Name**	**MI**

Date of Birth	**Date of Membership**	**Social Security Number**
		/ /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class	Relationship to Insured	Date of Birth	Percent (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class	**Relationship to Insured**	**Date of Birth**	**Percent (Must equal 100%)**

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	Relationship to Insured	Percent
One Beneficiary of a class Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the Insured.

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.
** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

MILTON FIRE DISTRICT NO. 1
SERVICE AWARD PROGRAM

BENEFICIARY DESIGNATION FORM

By completing this form, you designate who is to receive any death benefit that may be payable under the provisions of the above named service award program. Completing this form does not guarantee that a benefit will be paid upon your death. It is important that you provide all the requested information in the event that we have to attempt to locate your beneficiary. If all of your beneficiaries listed below are deceased, the death benefit will be paid to your estate.

Please consult with an attorney before naming a minor child or your estate as a beneficiary; typically death benefits can not be paid directly to a minor. To name more than 3 primary or contingent beneficiaries, please complete two forms and indicate "page 1 of 2" on the first form and "page 2 of 2" on the second form.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK

********** PARTICIPANT DATA - PLEASE FILL OUT COMPLETELY **********

Volunteer First Name, MI, Last Name _____ Social Security Number ___-___-____ Date of Birth ___/___/____

Volunteer Mailing Address _____ City _____ State _____ Zip _____ Fire Company _____

********** PRIMARY BENEFICIARIES **********

Please list the person or persons you wish to receive the death benefit. If you list more than one person, each person listed will equally share the death benefit, provided they are alive as of your date of death. If one or more of your primary beneficiaries are deceased, the remaining primary beneficiaries will equally split the death benefit. If all of your primary beneficiaries are deceased, the benefit will then be paid to those you list under "CONTINGENT BENEFICIARIES".

	First, MI, Last Name	Relation	Date of Birth	Soc. Sec. No.	Mailing Address	City	State	Zip
1.								
2.								
3.								

********** CONTINGENT BENEFICIARIES **********

If all of your primary beneficiaries are deceased, the benefit will then be paid to those you list here. If one or more of your contingent beneficiaries are deceased, the remaining contingent beneficiaries will equally split the the death benefit.

	First, MI, Last Name	Relation	Date of Birth	Soc. Sec. No.	Mailing Address	City	State	Zip
1.								
2.								
3.								

********** SIGNATURE AND WITNESS **********

I hereby designate those named above as my beneficiaries and declare that this designation supercedes all previous beneficiary designations.

_____, _____ Volunteer Signature and Date

_____, _____ Witness Signature and Date

Witness must be a Notary, or an Official of the Fire District or Fire Department

Form Updated 11/5/2010

MILTON FIRE DISTRICT NO. 1
SERVICE AWARD PROGRAM

FIREFIGHTER REQUEST TO NOT PARTICIPATE

TO: Milton Fire District No. 1 Board of Fire Commissioners

I, _____, request to not participate
Name of Firefighter

in the Milton Fire District No. 1 Service Award Program. I understand that by signing below I permanently waive all rights to all Service Award Program service credit and cash benefits that I or my heirs may have otherwise been entitled to receive as a result of my active service as a Milton Fire District No. 1 volunteer firefighter. I also understand that I can withdraw this request at any time by properly completing, executing and then submitting to the Board of Fire Commissioners a "WITHDRAWAL OF REQUEST TO NOT PARTICIPATE " form, and that I would then be eligible to participate in said Service Award Program and that I and my heirs may be entitled to earn Service Award Program service credit and cash benefits from the Milton Fire District No. 1 Service Award Program derived only from my active firefighter service after the date such form is received by the Board of Fire Commissioners of the Milton Fire District No. 1.

_____ _____
Signature of Firefighter Date

Accepted by the Board of Fire Commissioners of the Milton Fire District No. 1 on:

_____ _____ _____
Date Name of Fire Chief/Commissioner Signature of Fire Chief/Commissioner

DEPARTMENT USE ONLY
MEMBERSHIP
DATE OF SERVICE FORM

CHIEF

I, _____, THE CHIEF OF MILTON FIRE DISTRICT NO.1, HEREBY RECOMMEND THE APPLICANT FOR MEMBERSHIP INTO THE VOLUNTEER FIRE COMPANY OF MILTON FIRE DISTRICT NO.1 FOR:

GROUP 1 _____ (JR. MEMBERSHIP) GROUP 2 _____ (SR. MEMBERSHIP)

_____
CHIEF'S SIGNATURE DATE

DEPARTMENT MEMBERSHIP COMMITTEE

_____ _____
SIGNATURE DATE SIGNATURE DATE

APPROVAL _____ RCFFD VOTES

REJECTED _____ RCFFD VOTES

RELEASE OF APPLICATION TO DISTRICT FROM DEPARTMENT

ON _____ THE ROCK CITY FALLS FIRE DEPARTMENT SECRETARY RELEASED A
(DATE)
COMPLETE APPLICATION ALONG WITH A CLEAN ARSON RECORD APPROVED BY THE SARATOGA SHERIFF'S DEPARTMENT OF THE RCFFD APPROVED CANDIDATE _____, TO THE
(NAME)
MILTON FIRE DISTRICT NO.1 SECRETARY.

_____ _____
RCFFD SECRETARY SIGNATURE DATE MFD NO.1 SECRETARY SIGNATURE DATE

BOARD OF FIRE COMMISSIONERS

WE THE UNDERSIGNED COMMISSIONERS OF THE BOFC APPROVE THE ABOVE APPLICANT FOR MEMBERSHIP INTO THE VOLUNTEER FIRE COMPANY OF MILTON FIRE DISTRICT NO.1:

_____ _____
COMMISSIONER SIGNATURE DATE COMMISSIONER SIGNATURE DATE

( ) ACCEPT ( ) REJECT

DATE OF SERVICE _____

BADGE # ISSUED _____ **MASK SIZE** _____

ARSON ( ) PHYSICAL/DRUG SCREENING ( ) WELCOME LTR ( ) SAR CO INS ( ) PROV BENE ( ) VFIS BENE ( ) LOSAP BENE ( ) MEMBERSHIP ID ( ) FOB ( ) ROSTERS ( ) SIGN PRO ( ) IAR ( ) LENS ( ) SH ( )