HAMMONTON FIRE

DEPARTMENT

HAMMONTON VOLUNTEER FIRE DEPARTMENT

MEMBERSHIP APPLICATION

1. Please fill out this application to the best of you knowledge

2. Once you are finished you can take this application to the clerk's office in Town Hall located at 100 Central Ave. or stop by the fire station you wish to join any Wednesday between the hours of 7:00 & 8:00 pm.

FIRE STATION LOCATIONS:

Station #1 located at Front St. & Passmore Ave.

Station #2 located at 51 N. White Horse Pike

Dear Applicant,

Welcome and thank you for you interest in becoming a volunteer with the Hammonton Fire Department. We here at the Hammonton Fire Department have a long and distinguished history of community service dating back to 1886, and look forward to continuing that proud tradition with the help of prospective members like you.

While volunteering with the Hammonton Fire Department may provide some of the most fun, challenging, and rewarding experiences of your life, the commitment you are making is not one to be taken lightly. Your fellow volunteers will be depending on you to pull your weight as part of the team, and the residents of Hammonton will be depending on you to protect and save their lives and property.

The Hammonton Fire Department is excited at the prospect of having you join and become part of our family, but only ask that you are sure of your commitment to fulfill the expectations of a volunteer member.

Good Luck & Thank You

MEMBERS OF THE HAMMONTON FIRE DEPARTMENT

Hammonton Volunteer Fire Department
Membership Application Form

PERSONAL:

Name:_____

Address:_____

_____

Home Phone Number: (____) _____-_____

Cell Phone Number: (____) _____-_____ *Cell Provider:_____
* Needed for cell phone text messaging system.

Email:_____@_____

Age:_____ Date of Birth:____/____/_____

Marital Status: _____

Emergency Contact Information:

Name:_____ Relationship: _____

Address: _____

_____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-____

Children(s) Name/Age/Date of Birth:_____

_____

Social Security Number: _____/____/_____

Birthplace: _____

If not USA where we're you born and when where you naturalized?

_____

Number of years as a Hammonton resident: _____

Drivers License: ( ) Yes or ( ) No

Drivers License Number: _____/_____/_____

Has you license ever been suspended or revoked? ( ) Yes or ( ) No

If yes, explain why: _____

_____

EMPLOYMENT:

Name of Employer: _____

Address of Employer: _____

_____

Employer's Phone # _____/_____/_____

Work Schedule: _____

Does you occupation require extend extended travel: ( ) Yes or ( ) No

ARREST RECORD:

Have you ever been convicted of a crime: ( ) Yes or ( ) No

If so how many times: _____

Explain the charge and circumstances of each arrest:

_____

_____

_____

_____

PHYSICAL CONDITION:

Height: _____ Weight: _____

Blood Type: _____

Do you have any physical impairment's: ( ) Yes or ( ) No

If so please explain: _____

_____

Are you presently under a doctor's care: ( ) Yes or ( ) No

If so please explain: _____

Family Physician: _____

_____

Please briefly list you medical history for the past 10 years:

_____

_____

_____

_____

Do you take any medication: ( ) Yes or ( ) No

If yes please list each and what they are for:

_____

_____

_____

Organization Membership:

Do you belong to any other community groups? ( ) Yes or ( ) No

If yes please list all civic, fraternal and/or religious groups you are a member of:

_____

_____

How many monthly meetings do you attend: _____

How much time can you devote to the fire company: _____

Do you understand that there are mandatory attendance requirements for fires, drills, meetings, and details: ( ) or ( ) No

Do you have any previous firefighting experience? ( ) Yes or ( ) No

If so, which department(s), how long were you a member and why did you leave.

_____

_____

_____

QUALIFICATIONS:

Can you drive a vehicle larger than a passenger vehicle: ( ) Yes or ( ) No

If so please list the vehicles and the nature of your experience:

_____

_____

Do you have CPR or any other first aid training: ( ) Yes or ( ) No

If yes, list the training: _____

_____

Can you climb a ladder: ( ) Yes or ( )No

Can you swim: ( ) Yes or ( ) No

Briefly explain why you want to join the Fire Department:

_____

_____

_____

_____

Who recommended you for membership: _____

Which company would you prefer to join: 1 or 2

I fully understand that the Hammonton Fire Department is a volunteer organization. I must and will comply with the Town of Hammonton ordinances that regulate the Hammonton Fire Department and agree to comply with Fire Department rules and Regulations and will at all times obey the orders to me by my superiors.

Date: _____ _____

Signature of Applicant

I hereby recommend this applicant for active membership in the Hammonton Volunteer Fire Department.

Chief: _____

Date: _____/_____/_____

(Multi Purpose Police Background Check)

To Whom It May Concern:

I hereby authorize the Chief of Police or his designees of the Hammonton Police Department bearing this release, or copy thereof, to obtain any information personally or copies of, your files, records, or references pertaining to me that will be utilized in a investigation for potential membership in the Hammonton Volunteer Fire Department.. This release is approved for disclosure of records of employment, educational records (including but not limited to academic, achievement, attendance, athletic, personal history and disciplinary records) medical records, credit records, (including but not limited to any record of charge, prosecution or conviction for criminal or civil offenses) I hereby direct you to release such information upon request to the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the Hammonton Police Department. Consent is granted for the Hammonton Police Department to furnish such information as described above, to Mayor and Council of the Town of Hammonton in the course of fulfilling its official responsibilities. I hereby you the custodian of such records, and any school college, university, or other educational institution, hospital, or other repository of medical records, credit bureau, lending institution , consumer reporting agency, retain business establishment, law enforcement agency, or criminal justice agency, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information, or any attempt to comply with it. I am furnishing my Social Security Account Number on a voluntary basis with the understanding such is not required by Federal statue or regulation. This serves as notice that the Hammonton Police Department will utilize this number only to facilitate the location of employment, military, credit, and educational records concerning me in connection with this application. This form also authorizes this institution to obtain my driving record on an annual basis from this date forward.

Copy of driver's license att. Y or N Driver's License # _____

Copy of social security card att. Y or N Social Security # _____

Date of Birth: _____/_____/_____

Full Name Printed: _____

Signature: _____

Address: _____

Date: _____/_____/_____

Position applicant is applying for with the Town of Hammonton:

_____

Reason for police background check: _____

Police background check completed by signature and date: _____

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134:

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ SSN: _____

Job Title _____ Sex: Male ◯ Female ◯

Home Phone: _____

Work Phone: _____ Height: ____ (ft) ____ (in) Weight ____ (lbs)

Can you read English? ..... Yes ◯ NO ◯

Has your employer told you how to contact the health care professional who will review this? Yes ◯ NO ◯

Check the type of respirator you will use (you can check more than one category):

a ___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b ___ Other type

☐ Half-face

☐ Full-facepiece type (includes gas mask)

☐ Powered-air purifier

☐ Supplied-air

☐ Self-contained breathing apparatus

Have you worn a respirator in the past?: ..... Yes ◯ NO ◯

If "yes," what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: ____ hours

Do you exercise? ..... Yes ◯ NO ◯

If "yes,' describe how often and what exercise activities are: _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ◯ NO ◯

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

2. Have you ever had any of the following conditions?

Seizures (fits) Yes ◯ NO ◯

Diabetes (sugar disease) Yes ◯ NO ◯

Allergic reactions that interfere with your breathing Yes ◯ NO ◯

Claustrophobia (fear of closed-in places) Yes ◯ NO ◯

Trouble smelling odors Yes ◯ NO ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis Yes ◯ NO ◯

Asthma Yes ◯ NO ◯

Chronic bronchitis: Yes ◯ NO ◯

Emphysema: Yes ◯ NO ◯

Pneumonia Yes ◯ NO ◯

Tuberculosis Yes ◯ NO ◯

Silicosis Yes ◯ NO ◯

Pneumothorax (collapsed lung) Yes ◯ NO ◯

Lung cancer Yes ◯ NO ◯

Broken ribs: Yes ◯ NO ◯

Any chest injuries or surgeries: Yes ◯ NO ◯

Any other lung problem that you've been told about: Yes ◯ NO ◯

Name _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job:	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum):	Yes ◯ NO ◯
Coughing that wakes you early in the morning:	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down:	Yes ◯ NO ◯
Coughing up blood in the last month:	Yes ◯ NO ◯
Wheezing:	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply:	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke:	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure:	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure:	Yes ◯ NO ◯
Any other heart problem that you've been told about:	Yes ◯ NO ◯

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest :	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
Any other symptoms that you think may be related to heart or circulation problems:	Yes ◯ NO ◯

7. Do you currently take medication for any of the following problems?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble:	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
Seizures(fits)::	Yes ◯ NO ◯

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

Eye irritation:	Yes ◯ NO ◯
Skin allergies or rashes:	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue:	Yes ◯ NO ◯
Any other problem that interferes with your use of a respirator:	Yes ◯ NO ◯

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes ◯ NO ◯

Name _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ◯ NO ◯

11. Do you currently have any of the following vision problems?

Wear glasses: Yes ◯ NO ◯

Wear contact lenses: Yes ◯ NO ◯

Color blind: Yes ◯ NO ◯

Any other eye or vision problem: Yes ◯ NO ◯

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ◯ NO ◯

13. Do you currently have any of the following hearing problems?

Difficulty hearing: Yes ◯ NO ◯

Wear a hearing aid: Yes ◯ NO ◯

Any other hearing or ear problem: Yes ◯ NO ◯

14. Have you ever had a back injury: Yes ◯ NO ◯

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet: Yes ◯ NO ◯

Back pain: Yes ◯ NO ◯

Difficulty fully moving your arms and legs: Yes ◯ NO ◯

Pain or stiffness when you lean forward or backward at the waist: Yes ◯ NO ◯

Difficulty fully moving your head up or down: Yes ◯ NO ◯

Difficulty fully moving your head side to side: Yes ◯ NO ◯

Difficulty bending at your knees: Yes ◯ NO ◯

Difficulty squatting to the ground: Yes ◯ NO ◯

Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes ◯ NO ◯

Any other muscle or skeletal problem that interferes with using a respirator: Yes ◯ NO ◯

Any additional comments you would like to make:

_____

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

Reviewer's Name (Print) _____ **Reviewer's Signature** _____ **Date:** _____

Reset Form

Hepatitis B Vaccine Declination Form

The following statement of declination of the hepatitis B vaccine must be signed by an employee who:

- Chooses **not** to accept the vaccine.
- Has had appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration and benefits of vaccination, given free of charge to the employee.

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 myself. 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.

Employee Signature:_____**Date:**_____

- This statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

An employer can not require:

- Employees to waive liability in order to receive the vaccine
- Participation in pre-screening as a prerequisite for receiving the vaccine.

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NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION

1711 Route 34 South • Wall Township, New Jersey 07727-3934
Telephone: (732) 798-8137 • (800) 852-0137

THIS NOTICE IS FOR YOUR INFORMATION.
Privacy Notice for our (Potential) Members – Please review it carefully

The New Jersey State Firefighter's Association (NJSFA) and each Officer and the Office Staff and all the Local Associations throughout the state strongly believe in protecting the confidentiality and security of the information we receive about you. This notice refers separately to the New Jersey State Firefighter's Association and each of the Local Associations by using the terms "us", "we", or "our". This notice describes our privacy policy and describes how we treat the information we receive about you.

Why We Receive and How We Use Information: We receive the initial information via a Membership Application and Physical Test Record, Form #100. The purpose of this application is to permit membership in our organization. This information is used to make sure the applicant is in compliance with New Jersey Statutes and our Compendium and By-Laws.

How We Receive Information: We get most of the information from you. The Secretary of the Local Relief Association forwards the application form to our office. The information that you give us when applying for membership generally provides the information we need. If we need to verify information or need additional information, we may obtain information from third parties such as physicians, hospitals and other medical personnel. Information collected may relate to your health or other information stated on the application.

How We Protect Information: We treat information in a confidential manner. Our Officers, Advisory Committee and Office Staff are required to protect the confidentiality of information. We access information only when there is an appropriate reason to do so. We also have safeguards to protect information. All Officers, Advisory Committee members and Office Staff are required to comply with our policies.

Information Disclosure: We may disclose any information when we believe it necessary for the operation of our Association, or where disclosure is required by law. The application if in question may be forwarded to our Association Medical Doctor for evaluation. We do not make any other disclosures of information to other organizations or companies who may want to sell their products or services to you. We will not sell your name or application information to any organization, corporation or catalog company.

Access to and Correction of Information: Generally, upon written request, we will make available your personal information for your review. Information received in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. This will be included under "Disclosure of Information".

AFTER COMPLETING YOUR PHYSICAL, SEPARATE THIS SHEET FROM THE APPLICATION AND PHYSICAL PAGE. PLEASE RETAIN THIS PAGE AND DO NOT RETURN IT TO YOUR LOCAL ASSOCIATION OR TO THE STATE OFFICE.

ONCE COMPLETED, RETURN THE ATTACHED APPLICATION/PHYSICAL TO YOUR LOCAL RELIEF ASSOCIATION SECRETARY.

NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION

1711 Route 34 South • Wall Township, New Jersey 07727-3934
Telephone: (732) 798-8137 • (800) 852-0137

PHYSICAL EXAMINATION GUIDELINES

VALID FOR ONE (1) CALENDAR YEAR FROM THE DATE OF THE PHYSICAL

1. AGE: Must be at least 18 years of age and not older than 57 years of age.
2. EYES: Must be 20/50 corrected, monocular vision permitted (with glasses, contacts, or surgical procedures).
3. HEARING: Loss of hearing acuity so as to be unable to perceive sounds within normal voice range with or without hearing aid.
4. NOSE: Any significant nasal obstruction to free breathing not subject to correction by surgery.
5. MOUTH: Conditions which impair ability to communicate.
6. NECK: Problems resulting from (a) Goiter; (b) Limited range of motion, which prohibits turning, extension or free movement of the neck; (c) Tracheotomy – existing openings at the lower portion of the neck connecting the windpipe to the outside environment for the purpose of easy breathing.
7. PULMONARY: Problems resulting from (a) Loss or removal of a lung; (b) Any pulmonary disorder which would limit the applicant's ability to perform; (c) Pulmonary Function Test below normal; (d) Chronic Obstructive Pulmonary Disease/Asthma.
8. CARDIO PULMONARY SYSTEM: Problems resulting from Heart Disease or Cardiomegaly.
9. PERIPHERAL VASCULAR SYSTEM: Problems resulting from (a) Varicose veins; (b) Aneurysms; (c) Lymphedema; (d) Thrombophlebitis; (e) Arteriosclerosis Obliterans; (f) Buerger's Disease; (g) Raynaud's Disease; (h) Arterio-Venous Fistula; (i) High Blood Pressure, not able to be corrected by medication. Acceptable blood pressure reading should be as follows (a) Systolic not higher than 150 but not lower than 90; (b) Diastolic maximum should be 100 mmhg and minimum 50 mmhg.
10. ABDOMEN: Problems resulting from (a) Organomegaly; (b) Signs of tenderness in an area; (c) Presence of masses such as hernias of various types.
11. GENITOURINARY SYSTEM: Problems arising from (a) Presence of abnormal masses; (b) Abnormal discharges from any of the orifices; (c) Active venereal Diseases; (d) Parasitic diseases; (e) Varicocele and Varices; (f) Hydrocele.
12. MUSCOLO-SKELETAL SYSTEM: Problems arising from (a) Congenital malformation; (b) Limitation of Motion; (c) Weakness; (d) Impairment or absence of one or more of the digits on either or both hands; (e) Impairment of function of the hands; (f) Missing toes if it interferes with ambulation; (g) Deformities of the spine, pelvis or extremities.
13. OTHERS: Problems arising from (a) Disqualification for psychiatric conditions must be determined by local agencies; (b) Allergic conditions which are chronic and incapacitating; (c) Severe Anemia; (d) Active Peptic Ulcer; (e) Diabetes; (f) History of epilepsy or seizures other than documented febrile convulsions in childhood; (g) Alcoholism or drug addiction; (h) Removal of vital organs; (i) Any other condition not listed above which would render the applicant incapable of performing their duties as a firefighter.

THESE MEDICAL GUIDELINES ARE TO BE FOLLOWED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT LICENSED IN THE STATE OF NEW JERSEY WHEN EXAMINING AN APPLICANT FOR MEMBERSHIP. ANY ABNORMAL FINDINGS MUST BE EXPLAINED IN THE REMARKS SECTION OF THE APPLICATION. ALL SECTIONS OF THE PHYSICAL MUST BE COMPLETELY AND PROPERLY FILLED OUT OR THE APPLICATION WILL BE RETURNED.

ASSOCIATION #	COMPANY #	LINE #
FOR STATE OFFICE USE ONLY		

New Jersey State Firefighter's Association Application for Membership

Form 100 – REV 9/23

Date _____

Relief Association Name _____ Assoc. Number _____ Municipality _____ County _____

Fire Company Name _____ Fire Department Name _____

Applicant Name _____
First Middle Initial Last Suffix

Home Address _____
Street Municipality Zip Code # of years

Date of Birth _____ Birth Place _____ SS # _____ **(REQUIRED)**

Applicant Phone Number _____ Applicant Email Address _____

Have you ever applied to be a member of the NJSFA? ☐Yes ☐No If yes, when _____ where _____

If you have a line number with another Relief Association: ☐ Stay with previous Association ☐ Move records to new Association

* **It is the Applicant's responsibility to notify their Local Relief Secretary of any address change throughout their career/membership.** *

Signature of Applicant (witnessed by a Notary Public): _____

State of New Jersey, County of _____,

On _____, 20_____ before me, _____, Notary Public in and for said county, personally appeared

_____, (signer) who has satisfactorily identified himself/herself as the signer to the above referenced document.

My Commission Expires: _____ _____ (Affix Notary Stamp or Seal)
Notary Public Signature

_____ _____
Signature of Relief Association Secretary Signature of Chief of Department

Type of Firefighter the Applicant will be: ☐ Career (full time paid) ☐ Volunteer

Municipal/Fire District Approval: I hereby certify that this applicant was admitted to active membership in the Department and has been approved by the governing body of _____ on the ____ day of _____, 20_____.

Signature of Municipal Clerk/Board of Fire Commissioners: _____

A. Application portion should be completed by Applicant – Typed or Printed ONLY
B. Application must have the Physical Test Record completed by a New Jersey Licensed Physician, Nurse Practitioner or Physician's Assistant
C. The completed Application and Physical Test Record must be returned to the Local Relief Secretary
D. The Local Relief Secretary shall review the application for completeness, attain the proper signatures, and forward to the NJSFA State office.

The Applicant is not a member of the NJSFA until the completed ORIGINAL hard-copy application is received AND approved at the NJSFA State office. Do NOT scan & email. Original hard-copy only will be processed.

Form 100 – REV 9/23

Physical Test Record (Valid for one (1) year from the Date Examined)

To be filled out by a Physician, Nurse Practitioner or Physician's Assistant that is licensed in the State of New Jersey. Once the Physical has been completed, this form must be returned to the Local Relief Association Secretary at the address listed below.

All sections of the Physical must be properly filled out. If improperly filled out or questions are left blank, the Physical will be returned for correction or completion. NO SECTION CAN BE LEFT BLANK.

Please Print

Name _____ _____
First Middle Initial Last Sex

☐ W. N. L.

Age _____ Height _____Ft. _____In. Weight _____ Lbs. Hearing: ☐ Other: _____ BP _____
(Numbers Please)

Eyesight: Left_____ Right _____ Both (Corrected) _____
(Numbers Please) (Monocular Vision Permitted)

Has Applicant any apparent disabilities in:

Facial _____ Pulmonary _____

Cardio Pulmonary_____ Vascular _____

Abdomen _____ Genitourinary _____

Musculo-Skeletal _____ Other _____

The Applicant is free of any, other than listed above, medical or physical conditions that would cause harm to him/her or any other firefighter(s): ☐ YES ☐ NO (If no, explain below)

Has Applicant ever suffered from injury? ☐ YES ☐ NO If so, what and when? _____

_____

_____

Remarks / or rejection is based on: _____

_____

_____

_____

I CERTIFY THAT AS A PRACTICING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT LICENSED IN THE STATE OF NEW JERSEY, THE APPLICANT IS FREE FROM ANY ACUTE OR CHRONIC DISEASE AND HAS NO PHYSICAL DEFECTS THAT WOULD HINDER HIS/HER ABILITY TO PERFORM THE DUTIES OF A FIREFIGHTER.

Date Examined _____ Examined at _____
Address of office

☐ Physician

_____ _____ _____ ☐ Nurse Practitioner
Examiner's Phone # Print Examiner's Name Signature of Examiner

☐ Physician's Ass't

* If a Nurse Practitioner or Physician's Assistant, please indicate the name of the collaborating or supervising physician *

_____ _____
NPI Number Print Physician's Name

THE NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION RESERVES THE RIGHT TO HAVE THIS APPLICATION REVIEWED BY A MEDICAL DOCTOR OF ITS CHOICE, INCLUDING A NEW PHYSICAL EXAMINATION IF NECESSARY.

This Application/Physical must be returned to the local Relief Association Secretary:

_____ _____ _____
Local Relief Secretary Name Address Zip code