



UNITED HOOK & LADDER

21 North Bolton Street • New Oxford, PA 17350
717-624-7456 • 717-624-7722 fax

General Information for Prospective Active Members

Our monthly meetings are generally held on the first Wednesday of each month at 7:30pm in the dining hall of the New Oxford station. After you have met with the board of officers the following meeting is when your application is voted upon. You will be notified of the results of the voting by mail.

If applying for Active membership we ask that you:

1. Attend as many functions as possible. Dates and times are posted on the blackboards in both buildings, or on our website at www.33Fire.com
2. If you are a member of another fire department and have certifications, we ask that you get copies to us for our records.
3. You should contact a chief or line officer for your in-house training to familiarize yourself with the equipment. This must be completed for clearance to respond on our emergency calls.
4. If you do not have any fire training and wish to do so, there are courses that are posted on the cork board in the apparatus room and all dates for training are announced at the monthly membership meetings.
5. If you wish to become certified on the ambulance, you should see an ambulance officer for information.
6. Active membership does not require you to take any fire or EMS training. We do ask that you assist with our functions as much as possible.
7. Active members wishing to participate in Fire, EMS, or Fire Police duties must abide by the medical evaluation Standard Operating Guidelines

All members serve a six (6) month probationary period. During this time you are not permitted to vote on any matters. Once you have successfully completed your probation you will be eligible to vote on company matters if you meet the meeting attendance requirements. The fire company does not pay for any training you might take during this time, except by board approval only.. Any courses you wish to take that require a fee must be approved by the board of officers. The policy for taking courses is that you pay for them and upon completion, the department will reimburse you.

In order to maintain your voting rights after your probation, you must attend five (5) meetings in a twelve (12) month period. Records are kept by signing the roster at meetings. If you are unable to attend meetings due to work, you may submit a letter to the secretary which will be evaluated by the Board of Officers to determine and maintain your right to vote.

Death benefits are paid through our department and the Adams County Volunteer Emergency Services Association (ACVESA), provided we have your correct beneficiary information on record.

Building access cards and key fobs are available from the trustees. Additional or replacement cards and key fobs may be purchased as needed.

All gear and pagers are department property issued by the deputy chief. All records of serial numbers are kept by the department. Upon termination of membership, all equipment must be returned.

Functions and fundraisers are a big part of our organization's continued success. Any help that you can give is greatly appreciated.

www.33FIRE.com



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General Information for Prospective Social Members

Our monthly meetings are generally held on the first Wednesday of each month at 7:30pm in the dining hall of the New Oxford station. After you have met with the board of officers the following meeting is when your application is voted upon. You will be notified of the results of the voting by mail.

If applying for Social membership we ask that you:

1. Attend as many functions as possible. Dates and times are posted on the blackboards in both buildings, or on our website at www.33Fire.com
2. As a social member you are not asked to participate in any fire or EMS related activities.
3. The department does not pay for any training or courses for social members.

All members serve a six (6) month probationary period. During your six month probation you may not vote on any fire company matters and at the general election you can only vote on executive offices, if you meet the meeting requirements.

Death benefits are paid through our department and the Adams County Volunteer Emergency Services Association (ACVESA), provided we have your correct beneficiary information on record.

Building access cards and key fobs are available from the trustees. Additional or replacement cards and key fobs may be purchased as needed.

Functions and fundraisers are a big part of our organization's continued success. Any help that you can give is greatly appreciated.



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Application for Membership

Member Details

Active (Age 18+)
 Social
 Junior (Ages 14-17)

Name: _____ Phone: (____) _____

Address: _____

Date of Birth: ____/____/____ Sex: M / F SSN#: _____ - _____ - _____

Email Address: _____

References

-Recommending Member of United Hook & Ladder Company #33

Name: _____ Phone: (____) _____

-References outside the fire company

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

-Other Fire Companies you hold membership with (Please list all)

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

I hereby certify that I am of good moral character and I am physically fit to perform the duties required of me as a member of the United Hook & Ladder Company #33. I agree to be bound by the constitution, by-laws, rules, and regulations of United Hook & Ladder Company #33.

Signature: _____ Date: ____/____/____



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Application for Membership Continued

Applications including the beneficiary form, medical form, Authorization and Consent for Release of Information form and emergency contact form must be completed in full and returned to the Secretary along with \$16.50 which includes the \$6.50 application fee and the \$10.00 fee for a background check.

United Hook & Ladder Company #33 uses BG&H Investigations for the background checks. The results of your background check will be sent directly to United Hook & Ladder Company # 33 and will be kept confidential. Typical turn around for background checks is under a week.

After United Hook & Ladder Company #33 receives all the necessary documents, forms, fees and your background check, your application will be processed and you will be notified. This notification will include an invitation to appear before the Board of Officers for a brief orientation as to what to expect as an applicant for membership and to answer any questions you may have about our organization and policies.

All applicants are subject to investigation by the investigative committee and the Board of Officers of United Hook & Ladder Company #33.

All applicants must serve 6 months probation and membership is based on approval by the Board of Officers of United Hook & Ladder Company #33.



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Emergency Contact Form

Primary Contact

Name: _____

Street Address: _____

City ST Zip _____

Telephone #: _____

Secondary Contact

Name: _____

Street Address: _____

City ST Zip _____

Telephone #: _____

Physician's Name: _____

Telephone #: _____

BG&H Investigators, LLC
AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION For
Employment/Membership

Thank you for your application with United Hook & Ladder Co. # 33 (Hereinafter referred to as Company.) As a condition of employment/membership, and/or continued employment/membership, that all applicants consent to and authorize a pre-employment/pre-membership verification of their background, including, but not limited to, information submitted on their application or résumé.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment/membership is true and complete to the best of my knowledge. I understand that if I am employed/granted membership, any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that the Company may now, or at any time while I am employed, conduct a verification of my education, previous employment/work history, credit history, motor vehicle records, contact personal references, require that I provide a urine specimen to be tested for the presence of drugs or alcohol, investigate worker's compensation claims and obtain any criminal or civil history record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any state or province or any information as deemed necessary to fulfill the job requirements.

I authorize BG&H Investigators, LLC and any of its agents/designated Company Personnel or affiliates, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of the Company.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers and other organizations and Agencies to provide BG&H Investigators, LLC with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge the Company, its agent, BG&H Investigators, LLC, and their associates to the full extent permitted by law from claims, damages, costs, and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information.

Please Complete the form below:

APPLICANT:

Signature		SS#:	
Name typed or printed		Date	
Address	License #	Type	State
City	State/Zip	Date of Birth	

NOTE: Birth date is used only to verify criminal and civil records and will not be used by this organization to make a hiring decision.

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ Date _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

Specifying Beneficiaries

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* 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.



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: _____

- 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." | | |
| 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." | | |
| 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." | | |

Questions:

REMARKS:

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

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