Town of Kearney
8 Main Street, P.O. Box 38 Kearney, ON P0A 1M0
Telephone: (705) 636-7752 Fax: (705) 636-0527 Email: admin@townofkearney.ca

Volunteer Firefighter/First Responder Application Form

Personal information on these forms is collected under the authority of the Freedom of Information Act, and will be used to determine eligibility for employment as a Volunteer Fire Fighter. Questions about this collection of personal information should be directed to the Fire Chief of Kearney Fire Department, 111 Main Street, Kearney, Ontario P0A 1M0. 705-636-7402.

Contact Information

Surname:	Given Name:
Address:	
Home Phone:	Cell Phone:

Employment Information

Are you eligible to work in Canada: □ Yes □ No	Are you at least 18 years of age? □ Yes □ No
Current Employer:	Occupation:
Address:	Supervisor:
Duties/Responsibilities:	
Does your employer support your involvement in	the local Fire Department? □Yes □ No
Length of current employment:	
Former Employer:	Occupation:
Address:	Duties:

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Education & Training

Highest Level of Education:	Diploma/Degree:
Driver's License: □ Yes □ No	Class:
Courses/Workshops/Seminars (list relevant):	
First Aid Training/Certificates:	
Attendance Requirements include making 75% of scheduled training events. Please verify that you can meet this requirement: Yes No	

Availability In Emergencies (check applicable)

Able to respond to:	**Day**	**Night**	**Weekend**

References

Name:	**Phone:**	**Relationship:**□work □ personal
Name:	**Phone:**	**Relationship:**□work □ personal
Name:	**Phone:**	**Relationship:**□work □ personal
Name:	**Phone:**	**Relationship:**□work □ personal

I _____ authorize the Town of Kearney to contact the persons or organizations listed on this document for the purpose of obtaining reference information including information contained in my personnel file. These persons are authorized to disclose such information.

Potential members will be interviewed by the Fire Chief of the Kearney Fire Department.
Applicants shall be subject to a physical examination by a physician licensed in the Province of Ontario at the applicant's expense.
Applicants shall be required to supply a CPIC check. (Cost if any to be reimbursed to the applicant if hired)
Accepted applicants are subject to a twelve-month probationary period and are required to successfully complete minimum training requirements before full status is granted.

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Have you ever been convicted of a criminal offence for which you have not received a pardon?
□ Yes □ No Describe:

Applicants Name: (print)_____

Applicants Signature:_____ Date: _____

Witness Signature: _____ Date: _____

Comments:

RELATED SKILLS OR EXPERIENCE CHECKLIST

Please indicate your level of proficiency with the skills listed by circling the appropriate number and providing a description of your experience using the following rating:
0 = No experience
1 = Familiarity acquired through personal experience, high school courses or related training
2 = Advanced skills level and/or post-secondary courses or apprenticeships
3 = A trade, license, recognized certificate or extensive experience

Previous Experience	**Level**				**Description**
Firefighting / emergency response	0	1	2	3	
Military/Police	0	1	2	3	
Mechanics	0	1	2	3	
Pumps, valves, sprinklers	0	1	2	3	
Electrical Systems	0	1	2	3	
Electronic Systems	0	1	2	3	
Computer Technology	0	1	2	3	
Building construction or design	0	1	2	3	
Breathing Apparatus or Scuba	0	1	2	3	
Blueprint reading	0	1	2	3	
Firefighting tasks	0	1	2	3	
Rescue Procedures	0	1	2	3	
Athletic sports or skills	0	1	2	3	
Languages	0	1	2	3	
Occupational health &safety	0	1	2	3	

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Photography	0	1	2	3	
Fundraising	0	1	2	3	
Office Equipment	0	1	2	3	
Typing, filing or telephones	0	1	2	3	
Public Speaking	0	1	2	3	
Teaching, facilitation or coaching	0	1	2	3	
Events Coordinator	0	1	2	3	
Radio Communications	0	1	2	3	
Medical / Health Sciences	0	1	2	3	
Professional Driver	0	1	2	3	
Heavy Equipment Operation	0	1	2	3	

Other Licenses or Certificates (please list)

C.P.R	Expiry Date:
First Aid	Expiry Date:
Defibrillation	Expiry Date
Ontario Driver's License □A □D □Z □F □G	Expiry Date:

Other Volunteer Experience

Organization Name	Length of Time with Organization

Annual Medical Statement of Personnel
Identification Information

Name:
Street Address:

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Mailing Address:
Phone Number:
Birth Date:
Full Time Occupation:
Name of Organization: KEARNEY VOLUNTEER FIRE DEPARTMENT
Name of Physician:
Phone Number of Physician:

Please explain any "Yes" answers in the "Remarks" column

Faculty	Question	Yes	No	Remarks
Eyesight	Have you lost use of either eye? L R			
	Is Peripheral vison restricted?			
	Are you colour blind?			
	Do you have cataracts? Treated?			
	Do you where contacts/glasses			
	Date of last eye exam			
Hearing	Do you have difficulty hearing normal conversation levels?			
	Do you use a hearing aid?			
Diabetes	Have you ever been treated for diabetes?			
	Describe current medications/dosage, if any and method of administration under "Remarks"			
	Date of latest blood sugar test			
Heart	Have you ever been treated for heart disease?			
	If "yes", describe condition			

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	Describe current medication and dosage, if any, under “Remarks”			
	Do you have a pacemaker?			
	Date of last treatment or check-up			
Epilepsy	Have you ever been treated for epilepsy?			
	If “Yes”, when was your last seizure?			
	Describe current medication and dosage, if any, under remarks			
Blood Pressure	Have you ever been treated for high blood pressure?			
	If “Yes”, when were you treated?			
	What was your last reading?			
	Describe current medication and dosage, if any, under “Remarks”			
Limbs	Have you lost an arm or leg?			
	Have you lost the use of an arm or leg?			
	Does your vehicle have special controls?			
Misc.	Have you ever had, or been treated for Convulsions?			
	If “Yes”, give date of last treatment and describe current medications			
	Have you ever had Fainting Spells?			
	If “Yes”, give date of last treatment and describe current medications			
	Have you ever had, or been treated for, Loss of Equilibrium?			
	If “Yes”, give date of last treatment and describe current medications			
	Have you ever been treated for Alcohol or Drug Abuse?			
	If “Yes”, give date of last treatment and describe current medications			
	Have you ever been treated for Mental Illness			
	If “Yes”, give date of last treatment and describe current medications			

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	Are there any restrictions posted on your Drivers License?			
	Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?			
	Are you physically fit to perform the duties of this position? Including Lifting and Carrying?			
	The position of a volunteer firefighter/first responder may put extreme mental and emotional pressure on individuals which requires certain emotional stability in situations of varying circumstances. Will this prove to be an issue?			
	Are there any physical or mental health issues that may be of concern?			

This Form to Be Completed by Physician:

Dear Physician;

_____ has applied to join the Kearney Volunteer Fire Department for the position of firefighter/first responder.

Please complete the attached questionnaire with regard to the applicant's ability to meet the physical, emotional and psychological demands of this position.

Applicant information:

Name: _____

Address:_____

Physician Information:

Name: _____

Address: _____

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Assessment:
Please review the attached role description carefully.

1. Is the applicant medically fit to perform the duties described □Yes □No

2. Is the applicant prescribed any medication that may affect his/her ability to perform the duties described?
   □Yes □No

3. Are there any other medical concerns that may impact on the individual's ability to perform the duties described? □Yes □No

   Comments:_____

I, the undersigned, am a legally qualified medical practitioner, licensed to practice in the Province of Ontario. This report confirms my evaluation and medical opinion of the applicant.

_____ _____
Signature Date