SOMERVELL COUNTY FIRE DEPARTMENT

111 Shepard St.
Glen Rose, TX 76043

TEL: (254) 897-2135
FAX: (254) 897-4568

APPLICATION

PLEASE READ FIRST: Thank you for your interest in the Somervell County Fire Department. The application you submit will be reviewed and evaluated based upon the information you have supplied. Failure to answer all questions completely and accurately may mean ineligibility.

PLEASE FOLLOW THESE INSTRUCTIONS TO COMPLETE THIS APPLICATION:

1. The fire department accepts applications but ONLY adds members or employees when there is such need.
2. You may submit a resume in addition to your application, but resumes will not substitute for a completed application.
3. The Somervell County Fire Department will contact (either by telephone, mail, or e-mail) the applicants selected for pre-placement testing and/or personal interview. All other applicants will receive no further notice.

SOMERVELL COUNTY FIRE DEPARTMENT

Application for Employment

AN EQUAL OPPORTUNITY EMPLOYER

Instructions: It is important that you answer all questions on this application fully and accurately. Failure to do so may delay its consideration and could mean loss of employment opportunities. If an item does not apply to you, or if there is no information to be given, please write in the letters "N.A." for Not Applicable. If completing a paper application, please print in blue or black ink or type.

The Somervell County Fire Department considers all applicants for membership or employment without regard to race, color, religion, ethnicity, gender, national origin, age, physical handicap, or any other protected status or classification in accordance with state and federal laws. The Somervell County Fire Department also provides "reasonable accommodations" to qualified individuals with known disabilities, in accordance with the Americans with Disabilities Act.

Position Applying For: _____ **Date:** _____
(Volunteer Member or Employee)

PERSONAL INFORMATION:

Name: _____ **Social Security Number #** _____
(Please Print) Last First Middle

Address: _____ _____
Number & Street **City** **State** **Zip Code**

Telephone No. _____ **Cell phone No.** _____
Include area code Include area code

Email address where we may contact you: _____

Date available to start membership or work: _____

Have you ever been employed or a member of the Somervell County Fire Department? ☐ **Yes** ☐ **No**

Dates of membership or employment? from _____ to _____

Do you have relatives working for or a member for the Somervell County Fire Department? ☐ **Yes** ☐ **No**

If yes, whom? _____ Relationship? _____

CITIZENSHIP:

Are you lawfully able to be employed in this country? ☐ **Yes** ☐ **No**

It will be necessary to submit documents as required by law to verify your identification upon employment.

EDUCATION, TRAINING, SKILLS, AND CERTIFICATIONS:

High School Graduate? ☐ **Yes*** ☐ **No** **GED?** ☐ **Yes** ☐ **No** **If GED, from what agency?** _____

*Name of High School: _____

Phone: _____

Additional Education: List colleges, trades schools, or other form of training above the high school level.

Name/ of School(s) Attended:	**Address/Phone**	**Number of Credit Hours**	**Type of Diploma, Degree or Certification**	**Major Subject**

Licenses or Certifications:

Computer Skills: ☐ MSWord for Windows ☐ Excel ☐ Access Other: _____

Machines or Special Equipment Operated:

DRIVING AND CRIMINAL RECORD:

State your Driver License is from _____ Check Type of License Held: ☐ A- CDL ☐ B- CDL ☐ Class C

Have you been issued a citation for any moving traffic violation(s) within the past three years for which you were convicted, served probation, took deferred adjudication or attended driving school? ☐ Yes ☐ No
If yes, please complete the following and attach additional sheet, if necessary:

Charge	Month/Year	Location – city/state
Charge	Month/Year	Location – city/state
Charge	Month/Year	Location – city/state

Have you ever been convicted of a crime other than a Class C traffic offense within the last ten years? ☐ Yes ☐ No
If so, please complete the following: (Note: Conviction will not automatically exclude you from employment.)

Charge	Month/Year	Location – city/state
Charge	Month/Year	Location – city/state
Charge	Month/Year	Location – city/state

MEDICAL AND SHOT HISTORY:

Do you have any medical condition(s) that will or could prevent you from performing the essential functions for the position being applied for?

☐ Yes ☐ No

Are you current on your vaccinations and can provide proof if needed: ☐ Yes ☐ No

EMPLOYMENT HISTORY:

List your employment experience, beginning with your current or last position and work back. Include military experience and account for periods during which you were unemployed. This page may be copied if additional space is needed to account for all employment in the **last ten (10) years.**

Are you presently employed? ☐ **Yes** ☐ **No** **If yes, may we contact your present employer?** ☐ **Yes** ☐ **No** ☐ **Later**

EMPLOYER: _____ **Dates of Employment: From** ____/____ **To** ____/____
mo./yr. mo./yr.

Address: _____ Telephone No. _____
Number & Street City State Zip Code

Position Title _____ Starting Salary $ _____ Ending Salary $_____ Hours per week: ___ _____

Supervisor's Name_____ Supervisor's Title _____

Describe Your Duties _____

_____

If Leaving; Reason for Leaving or Wanting to Leave _____

EMPLOYER: _____ **Dates of Employment: From** ____/____ **To** ____/____
mo./yr. mo./yr.

Address: _____ Telephone No. _____
Number & Street City State Zip Code

Position Title _____ Starting Salary $ _____ Ending Salary $_____ Hours per week: ___ _____

Supervisor's Name_____ Supervisor's Title _____

Describe Your Duties _____

_____

If Leaving; Reason for Leaving or Wanting to Leave _____

EMPLOYMENT HISTORY (continued):

EMPLOYER: _____ **Dates of Employment: From** ____/____ **To** ____/____
mo./yr. mo./yr.

Address: _____ Telephone No. _____
Number & Street City State Zip Code

Position Title _____ Starting Salary $ _____ Ending Salary $_____ Hours per week: ___ _____

Supervisor's Name_____ Supervisor's Title _____

Describe Your Duties _____

_____

If Leaving; Reason for Leaving or Wanting to Leave _____

EMPLOYER: _____ **Dates of Employment: From** ____/____ **To** ____/____
mo./yr. mo./yr.

Address: _____ Telephone No. _____
Number & Street City State Zip Code

Position Title _____ Starting Salary $ _____ Ending Salary $_____ Hours per week: ___ _____

Supervisor's Name_____ Supervisor's Title _____

Describe Your Duties _____

_____

If Leaving; Reason for Leaving or Wanting to Leave _____

Please explain any lapses in employment history:

Have you been fired or asked to resign from any job within the past ten (10) years? ☐ **Yes** ☐ **No** **If yes, Explain:**

PERSONAL REFERENCES: List three (3) references, excluding relatives.

Name & Occupation	Dates Known	Address	Telephone # (include area code)

1. _____

2. _____

3. _____

ADDITIONAL INFORMATION: In the space below, you may provide any additional information that you feel may be helpful in arriving at a decision concerning your qualifications for membership or employment.

EMERGENCY CONTACT:

Name: Phone: Alt. Phone

PLEASE READ CAREFULLY BEFORE SIGNING

PRE-EMPLOYMENT / MEMBERSHIP STATEMENTS

I certify the statements made by me in this application are true, complete, and correct to the best of my knowledge, and are made by me in good faith. I understand that any falsifications, misrepresentations or omission of facts in this application may be cause for my elimination from consideration for membership, hire, or, if already hired, cause for my dismissal.

I understand that if chosen for employment or membership I must undergo a drug test, a background check, and I may be required to undergo a job related physical requirements test, given at the county's expense. In addition, a Motor Vehicle Records search will be performed if this position requires use of a county vehicle. I further understand that any offer of employment or membership I receive may be contingent upon my passing any employment or membership related tests, examinations, background checks, and MVR searches if applicable.

I understand and agree that members or employees are "at-will" and such employment or membership with the Somervell County Fire Department is for no definite period of time and that any wages, benefits, and conditions of employment or membership can be changed at any time.

Pre-employment or Membership Drug Tests: I hereby authorize the Somervell Co. FD and its agents to conduct any urine drug tests they deem necessary. I understand that proper "chain of custody" procedures will be maintained and that the testing will be conducted by a NIDA Certified laboratory. I hereby authorize the release to the Somervell Co. FD all results of any drug tests performed by any doctors, clinics, or laboratories to which I have been referred. This information is authorized to be used by the Somervell Co. FD for the sole purpose of employment or membership related matters.

Release of Personal Data: I hereby authorize any investigator or duly accredited representative of the Somervell Co. FD to obtain any information from schools, residential management agents, employers, criminal justice agencies, or individuals, relating to my activities. This information may include, but is not limited to, academic, residential, achievement, performance, attendance, credit, disciplinary, driving, arrest and conviction records and personal history. I hereby direct you to release such information upon request of the bearer. I understand that the information released is for official use by the FD and may be disclosed to such third parties as necessary in the fulfillment of official responsibilities.

I direct you to release such information upon request of the duly accredited representative of any authorized agency regardless of any agreement I may have previously made with you to the contrary.

I hereby release any individual, including records custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply, with this authorization. A copy of this authorization shall be as effective as the original.

Return of Department Property: I agree that if I become a member or employee of the department that any issued equipment, gear, uniforms, radios, documents, or any other department property; will be returned within ten days after my departure from the department. This may be at my own will, or that of the department. Volunteer members who fail to report to the Chief for more than 30 days constitute an assumed departure from the department.

I have read and agree to the above policy, statements, and permissions. ☐ **Yes** ☐ **No**

Applicant's Printed Name _____
Last First Middle

Social Security Number: _____ Are you at least 18 years old? ☐ **Yes** ☐ **No**

Driver's License Number: _____ License Expiration Date:_____ DL Class:_____

Date of Birth: _____

Applicant's Signature _____ Date _____

PARENT OR GUARDIAN SIGNATURE _____
(If applicant under age 18, prior to pre-employment or membership drug screen/physical, parent/guardian will be required to sign)

DPS Computerized Criminal History (CCH) Verification (AGENCY COPY)

I, _____, have been notified that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)
History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply.

Because the name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization conducting the criminal history check for background screening is not allowed to discuss any criminal history record information obtained using the name and DOB method. Therefore, the agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (Automated Fingerprint Identification System). I have been made aware that in order to complete this process I must make an appointment with L1 Enrollment Services, submit a full and complete set of my fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company, L1 Enrollment Services,

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____ _____
Date DOB

_____
Agency Name

_____
Agency Representative Name

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ No _____ _____initial

Purpose of CCH: _____

Hire _____ Not Hired _____ _____initial

Date Printed: _____ _____initial

Destroyed Date: _____initial

Retail in your files

Rev. 02/02/2011

For Office Use Only:

Name:_____ **Issued ID #:** _____

Date of Hire: _____ **Position:** _____

Administrative Items:	Issued By:	ID Number (if applicable):
Key		
Pager		
Roster / Added to Roster		
Organizational Chart		
SOP Manual / Receipt Form		
VFIS Beneficiary Form		
Careflite Membership Form		
Physical / Drug Screen Form		
Personnel File Created		
Training File Created		
Structure Turn Out Gear:	**Issued By:**	**ID Number (if applicable):**
Locker		
Bunker Coat		
Bunker Pants		
Bunker Boots		
Gloves		
Helmet		
Helmet Shield		
Nomex Hood		
Flashlight		
SCBA Mask		
SCBA Mask Bag		

Wildland Equipment:	**Issued By:**	**ID Number (if applicable):**
Locker		
Wildland Over Jacket		
Wildland Over Pants		
Wildland Shirt		
Wildland Pants		
Wildland Belt		
Wildland Helmet		
Wildland Boots		
Wildland Gloves		
Wildland Bandana		
Wildland Goggles		
Deployment Pack		
Radio Harness		
Uniforms:	**Issued By:**	**ID Number (if applicable):**
Class A Uniform Shirt		
Class A Uniform Pants		
Class A Uniform Belt		
Class A Uniform Jacket		
Class B T-Shirts		
Medical / Shots:	**Issued By:**	**ID Number (if applicable):**
Hepatitis B Shot / Record		
TB Test / Record		
Tetanus Shot / Record		
Member/Employee Signature:		**Date:**

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:

O New Insured O Beneficiary Change O Name Change: From:-----------

Complete the following information:

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

O				
O		Policyholder		Policy Number
O		Policyholder		Policy Number
O		Policyholder		Policy Number
O	Other	Policyholder		Policy Number
O	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	Snouse	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 Equallv
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roaer Jones	Mother Sister Brother	50% 25o/o 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.