SOMERVELL COUNTY FIRE DEPARTMENT

111 Sheppard St.
Glen Rose, TX 76043

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

MEMBERSHIP

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 Membership

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 From:______________________________

*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: MS Word Excel Access Other

Machines or Special Equipment Operated: ______________________________

____

Please list any additional training, technical skills or professional knowledge that would support your application:

____

____

____

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 or NO

Are you current on your vaccinations and can provide proof if needed: YES or 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

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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:

____

____

<u>PERSONAL REFERENCES</u>: List three (3) references, <u>excluding</u> relatives.

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

1. ______________________________

2. ______________________________

3. ______________________________

<u>ADDITIONAL INFORMATION</u>: 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.

____

____

____

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: ____________________ 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, ____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) 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. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. 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. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company.

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

____
Signature of Applicant or Employee

__________________ __________________
Date D.O.B.

Somervell County
Agency Name (Please print)

Paula Stinson
Agency Representative Name (Please print)

____
Signature of Agency Representative

____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ______ NO _____ ________ initial

Purpose of CCH: ____________________________

Empl ___ Vol/Contractor ___ ________ initial

Date Printed:_______________ ________ initial

Destroyed Date:_____________ ________ initial

Retain in your files

Rev. 09/2013

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®

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.

3110 S. Great Southwest Parkway
Grand Prairie, Texas 75052
Members Services Office (877) 339-2273
A Texas 501(c)3 non-profit entity)

Caring – Heart Membership Application Somervell County, Texas

Somervell County
PO Box 38
Glen Rose, TX 76043
(254) 897-4814/897-2931 Fax

This membership benefit for you and your family is provided to you by Somervell County, Texas as an employee benefit. This form must be completed and turned in to the County Treasurer at the Courthouse Annex to activate your membership & receive its benefits.

First Name:____________________ Middle Initial:_____ Last Name: ____________________

Mailing/Home Address: ____

City:____________________ Zip Code:____________ Phone #: ____________________

Date of Birth:__________________________ □ Male □ Female

Do you participate in your employer's health insurance program? □ Yes □ No If you answered No to this question, please list your primary health insurance company: ______________________________________

Other Family Members of Your Household:

First Name:____________________ Middle Initial:______ Last Name: ____________________

Date of Birth:__________________________ □ Male □ Female

First Name:____________________ Middle Initial:______ Last Name: ____________________

Date of Birth:__________________________ □ Male □ Female

First Name:____________________ Middle Initial:______ Last Name: ____________________

Date of Birth:__________________________ □ Male □ Female

First Name:____________________ Middle Initial:______ Last Name: ____________________

Date of Birth:__________________________ □ Male □ Female

(For additional household family members, please copy this page and attach to this application)

By submitting this application, I agree (on my behalf and on behalf of my family) in consideration of the benefits provided to abide by the terms of the Caring-Heart Membership Program, which are shown on the back of this application. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me or my household family members by CareFlite. I authorize any holder of any of my medical information or that of my household family members to release that information to CMS, its agents or carriers, or CareFlite in order to determine benefits payable on my behalf or on behalf of my family members, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. I understand that under Texas rule 15 7.11 if I or a household member is a Medicaid recipient, than I am not allowed to have them on this application. Therefore I am stating that I have not listed on this application anyone that is a Medicaid recipient. If a household family member subsequently becomes a recipient of Medicaid, I will notify CareFlite in writing of this change immediately. I warrant that all of the information on this application is true and correct. CareFlite reserves the right to request documentation to verify the accuracy of any such information. I acknowledge that membership in CareFlite's Caring-Heart Membership Program is an EMS membership in a program sponsored by CareFlite and is not a membership in CareFlite's non-profit entity as the term "membership" is contemplated under the Texas Non-Profit Corporation Act. By signing this form, the Employee agrees to the terms and conditions of this program and the rules provided on the reverse side of this form.

____
Employee Signature

For County Use Only: Date Rec'd: ________________
Forwarded to CareFlite on: ____________________

For CareFlite Office Use Only:

Date Received:________________ Membership # Assigned:____________________ Initials:__________

3110 S. Great Southwest Parkway
Grand Prairie, Texas 75052
Members Services (877) 339-2273
(A Texas 501-c-3 non-profit entity)

Caring – Heart Membership Program

PERSONS COVERED: This Agreement covers the household family members listed on this application, so long as they remain full-time residents (including college students) of my household. New residence family members may be added, others deleted or the household location changed by written notice to CareFlite at the address shown above. Added members will be effective as of the postmark date on the envelope. Medicaid recipients are not permitted to enroll in this program.

EFFECTIVE DATE: This application will be effective on the date agreed to in the contract between CareFlite and the company shown on the reverse side of this form.

BENEFITS: Payment of the membership fee by the company shown above and compliance with the terms of this program/agreement entitles the members shown on the reserve side to the following benefits:

1. Emergency helicopter air ambulance services originating within 150 miles of DFW Airport for medically necessary advanced or basic life support emergency transport services from CareFlite as a result of an emergency medical condition shall pay nothing out of pocket, unless otherwise specified herein.
2. Emergency fixed wing air ambulance services for patients needing a higher level of care originating within 500 miles of DFW Airport and within the United States shall pay nothing out of pocket. For non-medically necessary fixed wing transports, CareFlite will make its best efforts to obtain an insurance pre-authorization. For fixed wing air ambulance service that are not medically necessary and/or operated for patient or family convenience, CareFlite will give members a 50% discount from its standard rates.
3. CareFlite's ground ambulance and 911/EMS service will be available with its service areas. These benefits will follow the rules of this Air Ambulance membership program.
4. CareFlite has made arrangements with certain other air medical programs in Texas to honor your Caring-Heart Membership in their operating areas. For more details, visit **www.careflite.org**.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by CareFlite, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those CareFlite services specified in this Agreement. This benefit is subject to certain limitations specified in this agreement. As a condition of receiving this benefit, I hereby assign (hand over) to CareFlite all rights and benefits that I or the other family members of my residence have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services. Such payment sources are collectively referred to in this agreement as "insurance". I authorize the payment of all insurance benefits or payments to CareFlite. I understand that CareFlite will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance up to the amount of CareFlite's charges for its services. When requested by CareFlite, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any insurance or other third party payments for services provided by CareFlite, I will promptly forward those payments to CareFlite at 3110 S. Great SW Parkway, Grand Prairie, Texas 75052.

LIMITATIONS and CONDITIONS: Membership benefits extend to CareFlite's critical car, advanced or basic life support helicopter and fixed wing air ambulance services staffed with nurses, paramedics and pilots, Specialty Care Transport (a ground transport staffed similarly to CareFlite's air ambulance services) as well as ground ambulances staffed with quality trained paramedics and EMTs. Member benefits are not applicable to services rendered by any other provider. As a condition of receiving the benefits of membership with respect to any air or ground ambulance transport, members with insurance agree to and must comply with all coverage conditions of their applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non- emergency, yet medically necessary air ambulance services. (This requirement typically applies to fixed wing air ambulance and inter-facility ground ambulance only but not to helicopter or 911/EMS emergency services.) Non-insured household family members will automatically receive a 50% membership discount on CareFlite's standard charges for the services rendered. Some plans require certain documentation from the insured within a specified time limit or the plan(s) deny or reduce coverage for ambulance services. In the event the member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by insurance, the member will then forfeit membership benefit for failing to so comply and their membership can be revoked at CareFlite's discretion. Membership is available for sale only in those counties or jurisdictions shown on CareFlite's website **www.careflite.org** . Ground ambulance benefits are available to all members but only in CareFlite's ground ambulance service areas. The member must hold a membership that is in good standing at the time of service and the transport must originate in CareFlite's deemed service area with CareFlite as the transporting agency. CareFlite reserves the right to deny or revoke any membership for reasonable cause. If membership is revoked than all balances are due in full. CareFlite may terminate the membership program at any time upon notice to the members. If CareFlite terminates the program, members will have any unused, prorated portion of their membership fee returned. To protect member fees, CareFlite maintains a bond with an A rated insurance company.