HAYS COUNTY EMERGENCY SERVICES DISTRICT NO. 3
Volunteer Membership Application

3528 Hunter Road, San Marcos TX 78666
512.754.7963

Incomplete applications will not be accepted.

Place an X in box next to the division of the department(s) you are interested in being a part of.

Fire/Rescue	☐		Support	☐		SMART/Dive Team	☐	

APPLICANT INFORMATION		
Last:	First:	Middle:
Date of Birth:	SS #:	Email:
Home Phone:	Work:	Cell:
Address:		
City:	State:	Zip:
TX D/L #:	Exp. Date:	Class:
DD # from your D/L (Item #5 / up to 20 digits):		

EMPLOYMENT INFORMATION		
Current Employer:		
Employer Address:		
City:	State:	Zip:
Supervisor's Name:	Phone:	
Previous Employer:		
Employer Address:		
City:	State:	Zip:
Supervisor's Name:	Phone:	
Previous Employer:		
Employer Address:		
City:	State:	Zip:
Supervisor's Name:	Phone:	

EDUCATION AND TRAINING						
High School:	From:		To:		Diploma?	
College:	From:		To:		Diploma?	
Other:	From:		To:		Diploma?	

Place an X in box next to any certifications you currently hold.

Texas Commission on Fire Protection								
Structure Fire Protection	Basic	☐	Intermediate	☐	Advanced	☐	Master	☐
Other	☐							

State Firemen's & Fire Marshals' Association of Texas										
Firefighter	Intro	☐	Basic	☐	Int	☐	Adv	☐	Master	☐
Other	☐									

Do you have any fire experience?	Yes: ☐	No: ☐	If yes, where and how long?

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Texas Department of State Health Services
National Registry of Emergency Medical Technicians

ECA ☐	EMT-B ☐	EMT-I ☐	EMT-P ☐	
Do you have any EMS experience?	Yes: ☐	No: ☐	Where?	

REFERENCES

Name	Address	Phone
1.		
2.		
3.		

Why do you want to become a member of the South Hays Fire Department?

EMERGENCY CONTACT

Name:	Relation:	Phone:	
Address:	City:	State:	Zip:

CRIMINAL HISTORY (Use Back for Additional)

Have you ever been arrested?	Yes: ☐	No: ☐	

List all offenses, other than traffic you have been charged with, regardless of conviction.

Type of Criminal Offense	Class	Date
City	County	Disposition
Type of Criminal Offense	Class	Date
City	County	Disposition
Type of Criminal Offense	Class	Date
City	County	Disposition

DRIVING HISTORY (Use Back for Additional)

List all traffic citations.

Type of Citation	Date
City	County	Disposition
Type of Citation	Date
City	County	Disposition
Type of Citation	Date
City	County	Disposition

List all vehicle accidents you were the driver in, regardless of fault.

Date	City	County	At Fault: Yes ☐ No ☐
Date	City	County	At Fault: Yes ☐ No ☐

HAYS COUNTY EMERGENCY SERVICES DISTRICT NO. 3 Volunteer Membership Application			
DRUG/ALCOHOL USE			
List all medication you are currently taking that are prescribed to you.			
List all other drugs and medications you are currently taking.			
Explain all current or history of illegal marijuana and/or drug use.			
Explain your daily, weekly and monthly alcohol use.			
Are you willing to take a drug and/or alcohol test?	Yes: ☐	No: ☐	You could also be subject to one anytime in the future.
I authorize Hays County Emergency Services District No. 3 (ESD3), their Officers and representatives to obtain a criminal history, personal history, employment history and a driving history on me at any time. I will *immediately* inform the department of any changes in my criminal, personal, employment or driving history.			
I understand the use of illegal drugs, controlled substances and/or alcohol is prohibited on or in all ESD3 grounds, vehicles, equipment and property. I also understand that if performing duties under the influence of illegal drugs, controlled substances and/or alcohol, I will be subject to immediate termination.			
I will abide by all ESD3 policies including the SOG's and Rules & Regulations. I will strive to provide the best public safety services to our community by actively participating in community events and up-to-date fire and medical training. I will hold above all else, the safety of fellow members and my community. I will try to perform my duties to the best of my ability. I understand that my activities outside of ESD3 directly reflect on the department and will act accordingly.			
I understand that any ESD3 property issued to me such as gear, uniforms or communication equipment must be returned at the time of my resignation or whenever it is requested by my supervisors. Failure to do so will result in possible legal action and/or paying for the replacement of such property.			
I grant ESD3, its representatives and employees the right to take photos of me and my property in connection with any ESD3 program. I authorize ESD3, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that ESD3 may use such photos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and Web content.			
NOTICE: Omission or falsification of information on this government document is a felony.			
Signature of Applicant:		Date:	

Attach a copy of the front of your valid Texas Driver's License.

Drop off your completed application packet, in person, at:

South Hays Fire Station
3528 Hunter Road
San Marcos TX 78666

Monday thru Friday / 9am to 5pm

Hays County Emergency Services District No. 3
South Hays Fire Department
3528 Hunter Road, San Marcos TX 78666
Admin: 512.754.7963 Fax: 512.396.8051

Neighbors helping neighbors.

DISCLOSURE AND AUTHORIZATION FORM TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT/VOLUNTEER PURPOSES

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you for employment/volunteer membership and, if you are employed or volunteering, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, Hays County Emergency Services District No. 3 ("the Company") may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

IntelliCorp Records, Inc. can be contacted by mail at 3000 Auburn Dr, Suite 410; Beachwood, OH 44122; or phone: 1-888-946-8355; or website: www.intellicorp.net.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment/volunteer-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and

- an "investigative consumer report" is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act ("FCRA").

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for employment/volunteer purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

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AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize Hays County Emergency Services District No. 3 to obtain and rely upon consumer reports or investigative consumer reports concerning me. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in their decision about me.

I do _____do not_____ authorize you to contact *my current* employer for Employment and Reference Verifications

(This will authorize immediate inquiries to the Human Resources Department and to any listed supervisors or references in the Employment or Volunteer Membership/Reference Section of your application.)

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____
Printed Name

_____ _____
Applicant Signature Date

_____ _____
Parent or Legal Guardian Signature Date
(for searches conducted on minors under the age of 18)

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Personal Data

Last Name	First Name	Middle Name

Current Address	Dates Lived Here

Addresses for the Past Seven Years: (include street, city, state, zip code)	Dates of Residence:

Date of Birth	Other Names Used (including maiden name)	Years Used

Social Security Number	Driver's License #	State

Email address (may be used for official correspondence)

I have the right to make a request to **IntelliCorp Records, Inc**, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including sources of information, and the recipients of any reports on me which **IntelliCorp Records, Inc** has previously furnished within the two year period preceding my request.

I certify that all elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me will be sufficient grounds for rejection or discharge.

Printed Name	Applicant Signature	Date

MISSION STATEMENT

"To protect lives and property and to educate those who do, to a high standard of excellence".

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.

C01:008A (11/05)

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: _____

	Yes	No
2. Eyesight:		
a. Have you lost use of either eye? _____ R _____ L.....a.	☐	☐
b. Is peripheral (side) vision restricted?.....b.	☐	☐
c. Are you color blind? .....c.	☐	☐
d. Do you have, or have you ever had, cataracts?.....d.	☐	☐
e. Are actual deficiencies corrected by glasses or contact lenses?...e.	☐	☐
f. Date of last eye examination: .....f.	_____	
3. Hearing:		
a. Do you have difficulty hearing normal conversation level?.....a.	☐	☐
b. Do you use a hearing aid? .....b.	☐	☐
4. Diabetes:		
a. Have you ever been treated for diabetes? .....a.	☐	☐
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.	☐	☐
b. Describe condition:.....b.	_____	
c. Describe current medication and dosage, if any, under "remarks."		
d. Do you have a pacemaker? .....d.	☐	☐
e. Date of last treatment or check-up: .....e.	_____	
6. Epilepsy:		
a. Have you ever been treated for epilepsy?.....a.	☐	☐
b. If "Yes," when was your last seizure?.....b.	_____	
c. Describe current medication and dosage, if any, under "remarks."		

Questions:

REMARKS:

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

Member Acknowledgment of the Alliance Direct Contracting Program

Below is information that tells me how to obtain health care under my department's workers' compensation coverage. If I am hurt on the job, I understand that:

1. I must choose a "primary care physician" from the Alliance list of doctors which will serve as my "treating doctor".
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may seek emergency treatment.
3. I may have to pay the bill if I receive health care from a doctor other than an Alliance doctor without approval from the Texas Municipal League Risk Pool adjuster.

Signature_____ _____/_____/_____
Date

_____
Printed name

My address is:_____

Name of policy holder: Hays County ESD #3

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance).

Direct Contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or contact your adjuster.