27 W. Green St | Middletown, DE 19709 | 302.378.7799 | Fax 302.378.9130

HONORARY MEMBERSHIP APPLICATION
(PLEASE PRINT)

Full Name_____ Social Security #_____

Address_____ City_____ State_____

Phone Number_____ Number of years at this address_____

Number of years in community_____ Previous Address_____

E-Mail Address_____

Birth Date_____ Single_____ Married_____

Have you ever been a member of any fire company?_____

If yes, state name of company and dates_____

List three (3) references:

Name_____ Address_____

Phone_____

Name_____ Address_____

Phone_____

Name_____ Address_____

Phone_____

Employment Firm_____ Address_____

Phone_____ Your Position_____

Years Employed_____ Name of Supervisor_____

VOLUNTEER HOSE CO. ENGINE LADDER RESCUE EMS MIDDLETOWN, DE

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Police Violations, if any_____

Are you presently on disability?_____

If yes, describe reason_____

Have you ever received Workman's Compensation of disability insurance?_____

If yes, describe reason_____

Do you now, or have you ever, had heart problems?_____

Recommended by members:

_____

_____

_____

Investigating Committee:

_____

_____

_____

I give the Volunteer Hose Company Board of Directors permission to investigate me now or in the future. If elected, I promise to obey all the by-laws, rules, and regulations now in force or that hereafter may be adopted.

Signed_____

Office Use Only

Date Application Received_____

Date of First Reading_____

Date Voted Upon_____

Accepted_____ Rejected_____

DELAWARE STATE FIRE PREVENTION COMMISSION

DELAWARE VOLUNTEER FIREMEN'S CRIMINAL HISTORY AFFIDAVIT

This affidavit **must** be completed by all applicants for membership in a Delaware volunteer fire department and attached to the application for membership. Applicants must complete one of the two statements below. An application is not considered complete and shall not be processed until the notarized affidavit is attached.

AFFIDAVIT

I have never been convicted of an offense that constitutes any of the crimes set forth in **16 Del. C. §6647** (*attached hereto*) or any similar offense under any federal, State, or local law. I hereby certify that the statements contained in this application are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement in this application, I am subject to penalties prescribed by law, including denial or revocation of membership in the volunteer fire department and a mandatory fine of at least $1000 or a term of imprisonment of up to 2 years, or both.

_____ _____

Applicant's Signature Date

I am unable to submit the above statement. My written explanation as to what is not true with regard to the above statement and why is set forth below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

[Attach additional pages if needed along with a certified copy of your criminal history record from the appropriate authorities]

_____ _____

Applicant's Signature Date

_____ (County)

_____ (State)

Before me personally appeared, _____,
Applicant, of lawful age, to me known to be the identical person who signed this document of application and being by me first duly sworn, on oath state that all the foregoing statements are true and correct to the best of _____ knowledge and belief.

_____
Signature of Notary Public

_____
Printed or Typed Notary Public's Name

My Commission expires: _____

(Seal)

TITLE 16

Health and Safety

Safety

CHAPTER 66. FIRE PREVENTION

Subchapter IV. Volunteer Firefighters [Effective Sept. 15, 2007]

§ 6646. Definitions [Effective Sept. 15, 2007]

"Member" means a volunteer firefighter of a Delaware volunteer fire department, as certified by the Delaware State Fire Prevention Commission. (76 Del. Laws, c. 157, § 1.)

§ 6647. Membership requirements for volunteer firefighters [Effective Sept. 15, 2007]

(a) An applicant for membership in a Delaware volunteer fire department who has been convicted of or, had that applicant been charged as a juvenile, adjudicated delinquent of any of the following crimes is prohibited from serving as a firefighter in this State:

(1) A felony involving sexual misconduct where the victim's failure to affirmatively consent is an element of the crime, such as forcible rape;

(2) A felony involving the sexual or physical abuse of a child or of an elderly or infirm person, such as sexual misconduct with a child, sexual exploitation of a child, making or distributing child pornography, incest involving a child, or assault on an elderly or infirm person;

(3) A crime in which the victim is an out-of-hospital patient or a patient or resident of a healthcare facility, including abuse, neglect, or theft from or financial exploitation of a person entrusted to the care or protection of the applicant;

(4) Arson in the third, second, or first degree; reckless burning or exploding; cross or religious symbol burning; or any crime in which the applicant intentionally or recklessly started a fire or caused an explosion, or attempted or conspired to do so;

(5) A law of another state, territory, or jurisdiction which is the same or equivalent to the offenses described in paragraphs (a)(1) through (4) of this section.

(b) Membership in a Delaware volunteer fire department must be denied if the applicant has been convicted or, if that applicant was charged as a juvenile, has been adjudicated delinquent of any of the following crimes, except in extraordinary circumstances:

(1) Any crime for which the applicant is currently incarcerated, on work release, on probation, or on parole;

(2) Any crime in the following categories, unless at least 5 years have passed since the applicant's conviction or at least 5 years have passed since the applicant was released from custodial confinement, whichever occurs later:

a. A serious crime of violence against a person, such as assault with a dangerous weapon, aggravated assault, murder or attempted murder, manslaughter (other than involuntary manslaughter), kidnapping, or robbery of any degree;

b. A crime involving a controlled substance or designer drug, including unlawful possession or distribution of, or intent to unlawfully possess or distribute, a controlled substance in Schedules I through V of the Uniform Controlled Substances Act of Chapter 47 of this title;

c. A serious crime involving property, such as burglary, embezzlement, or insurance fraud;

d. Any crime involving sexual misconduct;

e. A crime of another state, territory, or jurisdiction which is the same or equivalent to the offenses described in paragraphs (b)(2)a. through d. of this section.

(3) In extraordinary circumstances, membership may be granted under subsection (b) of this section only if the applicant establishes by clear and convincing evidence that his or her membership will not jeopardize public health or safety.

(c) An applicant for membership in a Delaware volunteer fire department who knowingly provides false, incomplete, or inaccurate criminal history information, or who otherwise knowingly violates a provision of this subchapter, is guilty of a class G felony. In addition to a term of imprisonment of up to 2 years, the court shall impose a fine of no less than $1,000 which may not be suspended.

(d) The State Fire Prevention Commission shall adopt regulations to

implement the provisions of this subchapter. The regulations must include, as

part of the application form for membership in a Delaware volunteer fire

department, a dated and signed statement by the applicant swearing to or

affirming the following, if the following is true. If it is not true, the

applicant must explain in writing what is not true and why it is not true.

"I have never been convicted of an offense that constitutes any of the crimes

set forth in 16 Del. C. § 6647 or any similar offense under any federal,

state, or local law. I hereby certify that the statements contained in this

application are true and correct to the best of my knowledge and belief. I

understand that if I knowingly make any false statement in this application, I

am subject to penalties prescribed by law, including denial or revocation of

membership in the volunteer fire department and a mandatory fine of at least

$1,000 or a term of imprisonment of up to 2 years, or both."

(e) An applicant for membership in a Delaware volunteer fire department who is denied membership or whose membership is revoked because of the requirements of this subchapter may appeal the denial or revocation to the State Fire Prevention Commission within 15 days of written notification of the denial or revocation by the volunteer fire department. An appeal under this subsection must be held in accordance with the appropriate provisions of the Administrative Procedures Act, Chapter 101 of Title 29, and is subject to judicial review under subchapter V of Chapter 101 of Title 29. (76 Del. Laws, c. 157, § 1; 70 Del. Laws, c. 186, § 1.)

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Underage Authorization

I hereby give my/our permission for _____ to become a member of the Volunteer Hose Company of Middletown, since he/she is under the legal age of 18.

_____ _____

Parent or Guardian Date

Application Fee

I understand that there is an application fee of $20.00. I have enclosed the aforementioned fee with this application in the form of cash or check.

_____ _____

Applicant Date

_____

Parent or Guardian

VOLUNTEER HOSE CO. ENGINE LADDER RESCUE EMS MIDDLETOWN, DE

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Parental Consent for Physical/Drug Screening

I hereby give my permission for my son/daughter,_____,

to receive a physical/drug screen (circle one or both) from Christiana Care Occupational Health Services. I certify that I am the minor's parent or legal guardian.

Please note **"photo ID is required for this service."**

_____

Signature of Parent/Guardian

Date

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VOLUNTEER HOSE COMPANY OF MIDDLETOWN
PARENT/GUARDIAN CONSENT FORM
MINOR OVERNIGHT STAYS

To help improve response times, Volunteer Hose Company of Middletown (VHC) often has overnight crews at both Station 1 and Station 27. Members under the age of 18 are permitted to participate in overnight crews however are prohibited from sleeping in the station if they have school the following day. In addition, members under the age of 18 are not permitted to stay overnight at the Station without written consent from their parent/guardian.

If you wish to authorize your minor to participate in overnight crews, please complete the information below.

I _____ consent to the minor _____ participation in overnight crews with Volunteer Hose Company of Middletown.

Printed Name of Junior Firefighter	Signature of Junior Firefighter	Date
Printed Name of Parent/Guardian and contact number	Signature of Parent/Guardian	Date
Printed Name of Parent/Guardian and contact number	Signature of Parent/Guardian	Date

VFIS®
A Division of Glatfelter Insurance Group

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.	☐	☐
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**

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.

C01:008A

orm No. P-1 (10/12)
mail: pensionoffice@state.de.us
www.delawarepensions.com
Toll Free Number
Outside State of Delaware
1 - 800 - 722 – 7300

Office of Pensions
McArdle Building
860 Silver Lake Blvd, Suite
Dover, DE 19904-240
Telephone: (302) 739 - 420

STATE OF DELAWARE

MEMBER ACTUARIAL INFORMATION

PERSONAL DATA:

To be completed by Member (Please Print)

1. _____ 2. Soc. Sec. No.: _____
(Last Name) (First Name) (M.I.) (Maiden Name)

3. Address: _____ 4. Telephone No.: _____
(Number) (Street) (City) (State) (Zip Code)

5. Date of Birth: _____ 6. Gender: Male OR Female 7. Marital Status: Married Civil Union Single
(Month / Day / Year) (Circle One) (Circle One)

8. Organization: _____ Department ID: _____

9. Pension Plan: (Check One): State Employees': _____ State Police: _____ Judiciary: _____ Legislative: _____
C/M Police/Fire: _____ C/M General: _____ (LOSAP) Fire: _____ Port: _____

10. Effective Date of Hire with Present Organization: _____ 11. Current Annual Salary: _____

12. Have you previously been a member of any State of Delaware State Sponsored Pension Plan: Yes _____ No _____ If YES, list below:

PRIOR SERVICE CLAIMED (INCLUDE LEAVES OF ABSENCE AND INDICATE REASON)

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS
TOTAL PRIOR SERVICE CLAIMED				(ADD)		

13. (a) Did you serve in the Armed Forces of the United States: Yes _____ No _____
(b) If (a) is YES, show total Active Military Service:

FROM _____ TO _____ TOTAL CREDIT _____

(c) Did you begin a full-time vocational or professional training course within 5 years of your discharge and become a State employee within 5 years after the completion of that training: Yes _____ No _____
(d) If (c) is YES, show full-time vocational or professional training course dates, and date degree, diploma, or certificate granted:

FROM _____ TO _____ DATE OF DEGREE _____

14. Have you ever rendered full-time service in professional educational employment or other full-time employment for another State or the Federal Government, a county or municipality of the State of Delaware, a political subdivision of another State, or in an accredited private school or college: Yes _____ No _____ If YES, list below:

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS

15. Are you eligible for benefits as a result of any service listed in No. 14 above: Yes _____ No _____

DEPENDENT DATA:

16. Name of Spouse: _____ Gender: Male / Female
(Last Name) (First Name) (M.I.) (Maiden Name)

_____ Telephone No.: _____
(Street Address) (City) (State) (Zip) (If different)

Date of Birth: _____ Soc. Sec. No.: _____ Date of Marriage/Civil Union: _____
(Month/Day/Year) (Month/Day/Year)

ırried Dependent Child(ren):

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)
Address: ______________________ Telephone No.: __________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)
Address: ______________________ Telephone No.: __________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)
Address: ______________________ Telephone No.: __________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)
Address: ______________________ Telephone No.: __________

Gender: Male / Female Disabled: Yes / No

18. Dependent Parents: (Fill in only if parent(s) are receiving at least one-half of his or her support from you.)

Father's Name: ______________________
(Last Name) (First Name) (M.I.)
Address: ______________________

Date of Birth: __________ Soc. Sec. No.: __________ Telephone No.: __________
(Month/Day/Year)

Mother's Name: ______________________
(Last Name) (First Name) (M.I.)
Address: ______________________

Date of Birth: __________ Soc. Sec. No.: __________ Telephone No.: __________
(Month/Day/Year)

DESIGNATION OF BENEFICIARY FOR PAYMENT OF PENSION CONTRIBUTIONS
IF NO SURVIVOR'S PENSION IS PAYABLE

19. (If more than one name is listed, payment will be divided equally, unless otherwise specified.)

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: __________ Soc. Sec. No.: __________
(Month/Day/Year)

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: Male / Female

20. I hereby certify that all information given is accurate and true to the best of my knowledge and belief.

DATE: __________ SIGNATURE OF MEMBER: ______________________