



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 _____



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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



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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



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. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is peripheral (side) vision restricted?.....b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you color blind?c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have, or have you ever had, cataracts?d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are actual deficiencies corrected by glasses or contact lenses?...e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Date of last eye examination:f. | | _____ |

3. **Hearing:**

- | | | |
|---|--------------------------|--------------------------|
| a. Do you have difficulty hearing normal conversation level?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you use a hearing aid?b. | <input type="checkbox"/> | <input type="checkbox"/> |

4. **Diabetes:**

- | | | |
|--|--------------------------|--------------------------|
| a. Have you ever been treated for diabetes?a. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe condition:.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |
| d. Do you have a pacemaker?d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Date of last treatment or check-up:e. | | _____ |

6. **Epilepsy:**

- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for epilepsy?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when was your last seizure?.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |

Questions:

REMARKS:

7. Blood Pressure:

Yes No

- 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

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.



STATE OF DELAWARE MEMBER ACTUARIAL INFORMATION

PERSONAL DATA: To be completed by Member (Please Print)

1. _____
 (Last Name) (First Name) (M.I.) (Maiden Name) 2. Soc. Sec. No.: _____
3. Address: _____
 (Number) (Street) (City) (State) (Zip Code) 4. Telephone No.: _____
5. Date of Birth: _____
 (Month / Day / Year) 6. Gender: Male OR Female
 (Circle One) 7. Marital Status: Married Civil Union Single
 (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:

(INCLUDE LEAVES OF ABSENCE AND INDICATE REASON)

NAME OF ORGANIZATION	FROM		THROUGH		PERIOD COVERED	
	MONTH	YEAR	MONTH	YEAR	YEARS	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		THROUGH		PERIOD COVERED	
	MONTH	YEAR	MONTH	YEAR	YEARS	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)
- _____
 (Street Address) (City) (State) (Zip) Telephone No.: _____
 (If different)
- Date of Birth: _____ Soc. Sec. No.: _____ Date of Marriage/Civil Union: _____
 (Month/Day/Year) (Month/Day/Year)

Married 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: _____