

LADY'S ISLAND-ST. HELENA

FIRE DISTRICT

Firefighter Application

TO ALL APPLICANTS:

A firefighter must be physically fit and drug free. You will be required to complete and pass a physical, drug and pulmonary function test, as well as a physical ability test and a criminal record review.

A firefighter works 24 hour shifts with 48 hours off. You will be subject to be called in on off duty days. Work conditions will be hazardous at times and physically demanding.

Sleeping quarters are coed.

RETURN TO ADMINISTRATIVE OFFICE:

1. Completely filled out and signed application.
2. Completed and signed "Request for Criminal review"
3. Completed and signed "South Carolina Firefighter Registration Form." Only the areas denoted with an asterisk.
4. Copy of a valid South Carolina driver's license.



LADY'S ISLAND – ST. HELENA FIRE DISTRICT

237 Sea Island Parkway

Beaufort, South Carolina 29907

Phone: 843-525-7692 Fax: 843-525-7689



Bruce A. Kline, Chief

David C. Townsend, Chairman

(Please Print Clearly)

Date _____

Full name _____ Social security number _____

South Carolina driver's license number _____ Class _____

Present address _____

How long have you lived there? _____

Home telephone number _____ Cell phone number _____

Pervious address _____

How long did you live there? _____

Date of birth _____ Age _____ Sex _____ Height _____ Weight _____

Marital status _____

Referred by: Newspaper ____ Agency ____ Firefighter ____ Friend ____ Other ____

Are you willing to respond to calls day & night? _____

Do you have any physical or medical impairment or disability that would limit your job performance or the position for which you are applying? Yes ____ No ____

If yes, please explain, _____

Have you ever been convicted of a crime, excluding minor traffic violations Yes__ No__

If yes, please explain:

EDUCATION

Name of high school and the location: _____

Did you graduate? _____ GED: _____

Name of college if attended: _____

Did you graduate? _____ If yes, degree(s) received: _____

List any professional, trade, business or civic activities and offices held.

List any fire or medical schools attended. Include school name and dates completed.

In case of emergency notify _____ Relationship _____

Address _____ Telephone # _____

Cell Phone _____ Pager _____

Name of workplace/ address _____

WORK HISTORY

Begin with your present or most recent employer. List all positions held, including military services, if any. Please answer all questions in this section completely.

Name of company _____

Address _____ Telephone _____

Type of business _____

Starting date _____ Job title _____ Salary _____

Ending date _____ Job title _____ Salary _____

Description of duties _____

Immediate supervisor _____

Reason for leaving _____

May we contact this employer? _____

Name of company _____

Address _____ Telephone _____

Type of business _____

Starting date _____ Job title _____ Salary _____

Ending date _____ Job title _____ Salary _____

Description of duties _____

Immediate supervisor _____

Reason for leaving _____

May we contact this employer? _____

Summarize special skills and qualifications acquired from employment or other experiences.

References who are not relatives or previous supervisors:

Name _____ Telephone _____

Address _____

Name _____ Telephone _____

Address _____

Name _____ Telephone _____

Address _____

Name _____ Telephone _____

Address _____

All applicants selected for this position will be required to complete and pass an annual physical.

I certify that the answers given here are true and complete to the best of my knowledge.

Signature: _____ Date _____

South Carolina Firefighter Registration Act Request for Criminal Record Review

Name (Full Given Name) _____

Address: _____

City State Zip

Social Security # _____ - _____ - _____ Date of Birth ___/___/___

Driver's License: State _____ Number _____

Race: _____ Sex: Male Female

.....
I, _____ do hereby grant approval for the
(Print Name)

_____ to inquire and receive any and all
criminal information pertaining to me.

(Applicant Signature) (Date)

(Authorized Signature) (Date)

Mail Request To:
S.L.E.D. Records
PO Box 21398
Columbia, SC 29221-1398
Phone: 1-803-737-9000
Fax: 1-803-896-7022

S.L.E.D. Should Return Information to:

Lady's Island – St. Helena Fire District
Attn: Scott Goneke
237 Sea Island Parkway
Beaufort SC 29907

Reports should be returned
to the Fire Department – not
the Fire marshal's Office

*Note to Fire Departments:
Please include a self-addressed
envelope for return of report
from S.L.E.D.

South Carolina Firefighter Registration Form
South Carolina State Fire Marshal's Office
141 Monticello Trail
Columbia, South Carolina 29203

A. *Name: _____
Last First Middle

*Home Address _____

*Social Security Number ____ - ____ - ____ *Date of Birth _____

*South Carolina Driver's License Number: _____ Class D/L (Circle One) A B C D E F M G

Name of Employing Fire Department: Lady's Island - St. Helena Fire District

Fire Department Mailing Address: 237 Sea Island Parkway

City: Beaufort Zip Code: 29907 FDID# 07306

Telephone Number: (843) 525-7692 Status: Paid

Background Check Completed
 Date: _____
 (Necessary if Employed On or After July 1, 2001)

Employed Prior to July 1, 2001
 Employment Date: _____

By Signature I certify that the above named individual is eligible for registration under the provisions of Title 40, Chapter 80, South Carolina Code of laws.

 Fire Chief (Print Name) Date

 Fire Chief (Signature) Date

B. Please Check ACTION TAKEN

(For All Actions taken On or After July 1, 2001)

____ Employment Date(See Section 40-80-10.B.2)	Effective Date: _____
____ Termination	Effective Date: _____
____ Voluntary Separation	Effective Date: _____
____ Retirement	Effective Date: _____
____ Inactive	Effective Date: _____
____ Member of Multiple Departments -List: _____	
____ Other (Explain) _____	

C. Do Not Write below This Line
(For SCFM Use Only)

The named individual _____

Registered as a firefighter in the State of South Carolina
 Registration Number: _____ Date: _____

Denied Registration based on: _____

FR1 7/1/01

 Authorized Signature

**SOUTH CAROLINA
POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY**

Completion of this report is requested to assist your employer in meeting the knowledge requirement of the South Carolina Second Injury Fund.

Name _____ Department _____ Position _____

A. To the best of your knowledge do you have or have had any of the following medical problems?

Answer YES or NO

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ----- 1. Epilepsy | ----- 18. Ankylosis of joints - Joints that are stiff and will not fully move. Frozen joints |
| ----- 2. Diabetes | ----- 19. Hyperinsulism - Excessive insulin in the blood with low blood sugar and periods of weakness or fainting due to low blood sugar |
| ----- 3. Cardiac Disease | ----- 20. Muscular dystrophy |
| ----- 4. Arthritis | ----- 21. Arteriosclerosis - Poor circulation, cold extremities, pain in legs while walking |
| ----- 5. Amputated foot, leg hand or arm | ----- 22. Thrombophlebitis - Infection or inflammation of veins in legs - swelling or tenderness in calves of legs |
| ----- 6. Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75% bilaterally | ----- 23. Varicose veins |
| ----- 7. Residual disability from Polio | ----- 24. Heavy metal poisoning |
| ----- 8. Cerebral palsy - Do you have a weakness or stiffness of arms, legs or other body parts that resulted from birth, injury or diseases? Any spasticity? | ----- 25. Ionizing radiation injury - Have you been exposed to radiation and have developed sores that did not heal, vomited or bled freely? |
| ----- 9. Multiple sclerosis | ----- 26. Compressed air sequelae - have you ever had the bends? Problems produced by flying at high altitude or problems resulting from exposure to high atmospheric pressure as in scuba diving? |
| ----- 10. Parkinson's disease | ----- 27. Ruptured disc |
| ----- 11. Cerebral vascular accident - Stroke or ruptured blood vessel in the head | ----- 28. Hodgkin's disease |
| ----- 12. Tuberculosis | ----- 29. Brain damage |
| ----- 13. Silicosis - Chronic cough emphysema or other lung problems due to inhalation of dust | ----- 30. Deafness |
| ----- 14. Mental retardation | ----- 31. Sickle-cell anemia |
| ----- 15. Psychoneurotic disability which involved treatment in a recognized medical or mental institution | ----- 32. Cancer |
| ----- 16. Hemophilia - Do you bleed easily and have a hard time stopping the bleeding? | ----- 33. Pulmonary disease |
| ----- 17. Chronic osteomyelitis - Long-term infection of bones or sores of the skin that do not heal | ----- 34. Degenerative disc disease |
| | ----- 35. Any other pre-existing disease |

For "yes" responses above, indicate the nature of injury or illness and name of physician in Remarks: _____

B. Has any doctor ever restricted your activities?

Yes No

If so, please list the medical condition, what type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

C. Have you ever been assessed any percentage or permanent disability to any part of your body for any reason whatsoever?

Yes No

If so, please explain:

D. Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider?

Yes No

If so, please list the medical condition(s) being treated, the name of doctor(s), field of specialty, and address and telephone number.

E. Are you presently taking any medication?

Yes No

If yes, please list the name of the medication, the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication.

F. Have you ever had surgery to any part of your body?

Yes No

If yes, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed and the address and phone number of the doctor performing the surgery.

G. Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider?

Yes No

If yes, please list the name, address and phone number of all doctors, chiropractors, therapist or other health care provider who provided such treatment, the dates of the treatment and the diagnosis provided by the doctor, chiropractor, therapist, or other health care provider.

H. Have you ever had an injury that required you to miss time from work?

Yes No

If yes, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

I. Are you aware of any condition or injury that might impair or limit your ability to work for this company?

Yes No

If yes, please describe the condition or injury.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE

Employee Applicant: _____ Date _____

Employer Signature: _____ Date _____