

# 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.

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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

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References who are not relatives or previous supervisors:

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

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Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

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Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

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Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

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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

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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.

FR2 7/1/01



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

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.

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**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:

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**I HAVE READ AND FULLY UNDERSTAND THE ABOVE**

**Employee Applicant:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_