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

146 Lady's Island Drive
Beaufort, South Carolina 29907
Phone: 843-525-7692 Fax: 843-525-7689

Bruce A. Kline, Chief

Mr. Gordon Bowers, 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

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

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

Lady's Island – St. Helena Fire District
Attn: Scott Goneke
146 Lady's Island Drive
Beaufort SC 29907

*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: _____
_____

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