Atlantic Highlands Fire Department
10 East Highland Avenue
Atlantic Highlands, New Jersey 07716
(732) 291-2002

Serving the Community for Over One-Hundred and Twenty Five Years

Dear Applicant:

On behalf of the men and women of the Atlantic Highlands Fire Department, We would like to take this opportunity to thank you for picking up a membership application packet and showing an interest in joining a great organization that provides a very vital service to the residents of Atlantic Highlands.

Our history of over one-hundred and twenty five years has shown that the experience, friendships and the self-satisfaction that you will receive and develop over the time you are a member will be invaluable and an experience that you will never forget. We have members that have belonged to the Fire Department for just over a few months to well over fifty years.

We would ask that you fill out the attached applications in their entirety. Please make sure to answer each question completely. The applications need to be signed by you in the presence of a Notary Public who will authenticate your signature and appropriately seal the applications.

The applications may be dropped off at Atlantic Highlands Borough Hall, 100 First Avenue, Atlantic Highlands, New Jersey or you may come to the Atlantic Highlands Fire Department monthly meeting which is held on the second Monday of each month at the Emergency Services Building beginning at 7:00 p.m.

If you have any questions or would like to talk to someone regarding the membership application, please feel free to call the Fire Chief's Office at 732-291-2002. Since we are a volunteer organization, if no one answers the telephone, we would ask that you leave your name and telephone number and someone will get back to you.

We look forward to reviewing your membership application packet and welcoming you to the Atlantic Highlands Fire Department.

Sincerely,
Atlantic Highlands Fire Department
Membership Committee

INSTRUCTIONS ON FILLING OUT PAPERWORK TO JOIN THE ATLANTIC HIGHLANDS FIRE DEPARTMENT

1. Fill out the Atlantic Highlands Membership Application (White Application) and have it notarized. Bring that application down to the Police Department and turn it in, where you will then be finger printed.
2. Answer questions on the tan form, go to your Doctor (at your expense) and get the physical done. Make sure all the questions are answered and the Doctor signs it. Have it notarized and bring back to the Borough Administrator. There is a 180 day time limit from when the Doctor signs it and it is sent to the New Jersey Firemen's Association.
3. Fill out the 7 page OSHA Respirator Medical Evaluation Questionnaire and return it to Dr. Movva @ 37 East Washington Avenue Atlantic Highlands.
4. Fill out the Hepatitis B Consent Form and return it to the Fire Chief.
5. Fill out the Fire Fighter 1 Registration Form and return it to the Fire Chief.

Atlantic Highlands Fire Department
10 East Highland Avenue
Atlantic Highlands, New Jersey 07716
(732) 291-2002

MEMBERSHIP APPLICATION

FULL NAME: _____

STREET ADDRESS: _____

TOWN: _____ STATE: _____ ZIP CODE: _____

HOME PHONE NUMBER: (___)_____-_____ FAX NUMBER: (___)_____-_____

DATE OF BIRTH: _____ _____ _____ SS #: _____ _____ _____

DRIVERS LICENSE NUMBER: _____ _____ _____ STATE: _____

EMPLOYER: _____

OCCUPATION: _____ PHONE #: _____

COMPANY MEMBERSHIP APPLIED FOR; Circle Appropriate Company

Hose Company #1 Hose Company #2 Hook and Ladder Company #1 Squad One Juniors

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY AND EXPLAIN EACH IF NECESSARY:

1. Have you ever been arrested ? Yes / No (If yes, please explain with dates)

_____

_____

2. Have you ever been convicted of New Jersey State Statue 2C:17-1; *Aggravated Arson*, or *Arson* or *Failure to control or report dangerous fire* or *directly or indirectly pay or accept any form of consideration for the purpose of starting a fire or explosion* ? Yes / No
(If yes, please explain)

_____

_____

3. Have you ever been convicted of New Jersey State Statue 2C:33-3; False Public Alarm ? Yes / No (If yes, please explain)

_____

_____

4. Have you ever been convicted (or found guilty) of a crime or a disorderly persons violation ? Yes / No (If yes, please explain)

_____

_____

5. Have you ever been rejected membership by any other Fire Department or Rescue Squad ? Yes / No (If yes, please explain)

_____

_____

I acknowledge that consideration for membership is contingent on the results of a background check, the taking and submission of my fingerprints to the state and federal databases and that I may be required to submit to a drug screen. Therefore, I authorize the Atlantic Highlands Fire Department and/or the Atlantic Highlands Police Department to (1) Investigate the truthfulness of all statements made on this application; (2) Contact any person(s) that can verify information (3) Discuss the results of any investigation with other members of the Atlantic Highlands Fire and Police Departments and (4) Receive the results of the drug screen that will be evaluated by the Atlantic Highlands Fire Department and/or Police Department for membership purposes only.

_____

(Signature of applicant and date)

WHOM IT MAY CONCERN: I am an applicant for membership with the Atlantic Highlands Fire Department. The Atlantic Highlands Fire and/or Police Department needs to thoroughly investigate my background for membership. It is in the public's interest that all relevant information concerning my personal and employment history be disclosed to the Atlantic Highlands Fire and Police Departments. I hereby authorize any representative from the Atlantic Highlands Fire and/or Police Department bearing this release to obtain any and all information pertaining to me. The intent of this authorization is to provide full and free access to the background history check. I consent to your release of any and all public and private information that you may have concerning me, including my work record, my background, criminal history check including all arrest records and investigatory files. I understand my rights under Title 5, United States Code, Section 552a, the Privacy Act of 1974, with regard to access and to disclosure of records and I waive those rights with the understanding that the information obtained will be used by the Atlantic Highlands Fire and/or Police Department in conjunction with membership to the Atlantic Highlands Fire Department.

I hereby release you, your organization and ALL others, including but not limited to the members and officers of the Atlantic Highlands Fire and Police Departments, from liability or damages that may result from furnishing the information. I agree to indemnify and hold harmless the person to whom this request is presented to and the person presenting this request.

Sworn and subscribed to
before me this ____ day of
_____, _____

_____

_____
Signature Date

_____
Print Name

Middletown Township Fire Department
Training Academy
1 Kings Highway
Middletown, NJ 07748
732-615-3280 / 732-957-9369 (Fax)
fireacademy@middletownnj.org

FF1 Course Candidate Registration Form

Instructions: Type information into gray areas. Complete entire form and return to the Academy.

Registration is on a first come basis. The Academy reserves the right to allow entry to M.T.F.D. candidates prior to non M.T.F.D. candidates. Class size is limited to 25 candidates. M.T.F.D. Training Academy, Firefighter 1 classes are scheduled for Tuesday & Thursday evenings from 1900-2200 hours and Saturdays from 0800-1600 hours. Candidates should report to class approximately 15 minutes early for each class. Candidates must report to every class with full personal protective equipment and SCBA. Lunch will be provided for candidates on Saturday classes. Access to the Academy is strictly restricted to the W. Front St. and Nut Swamp Rd. entrances of Normandy Rd.

Name:	D.O.B.	Age:
NJ Division of Fire Safety #:	Social Security # (Last 4 only):	
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:
Company:	Department:	
Height:	Weight:	Shirt Size:	Waist Size:
Co./Dept. Contact:	Phone Number:	
Emergency Contact:	Phone Number:	
Candidate Signature:	Application Date:	

This form must be approved by a Company or Department Officer.

I attest that the applicant is a member of the above Fire Company, has successfully completed all prerequisite courses and is covered by Workers' Compensation and Liability Insurance.

Name: Title: Signature:

Academy Use Only Date Received: Received By:
Enrollment Confirmed with Student: ☐

MONMOUTH COUNTY FIRE ACADEMY
1027 Highway 33 East
Freehold, NJ 07728
Telephone 732-683-8857 / Fax 732-683-8978
William Itinger, Chief Training Officer
witinger@co.monmouth.nj.us
www.monmouthcountyfireacademy.org

Firefighter I Candidate Registration Form

Instructions: Fill in form entirely, print and fax to the academy. Incomplete forms will be rejected.

Required age is 18. Registration will be on a first come basis with preference given to Monmouth County registrants. Classes are held on Tuesday and Thursday evenings at 7 PM and Saturday and Sunday mornings at 8 AM. Plan on arriving 15 minutes prior to class time. Be prepared for each class – refer to the requirements listed on student syllabus. A copy of candidate's Driver's License **must** accompany this application.

Candidate:
Class Preference: _____ **Tuesday/Saturday** _____ **Thursday/Sunday** _____ **No Preference**

Name_____ D. O. B. _____ Age_____

SS# _____ Phone (H) _____ (C) _____

Street Address:_____

City: _____ State: _____ Zip _____

Fire Department /Company_____ Station # _____

Department Address _____

Department/Company Contact _____ Phone # _____

Emergency Contact _____ Phone # _____

Candidate Signature _____ Date _____

Candidate E-mail Address_____

Verification/Authorization:

_____ Fire Department History
_____ Response area of Department
_____ Standard Operating Procedures
_____ Exposure Control Plan
_____ RTK Station Walk-through
_____ Department Equipment Familiarization
_____ Written recommendation regarding the recruits ability to use an SCBA from PLHCP
_____ Organization Structure
_____ Candidate duties & Responsibilities
_____ NJ Right to Know
_____ OSHA PPE
_____ Station ID Number

I attest that the candidate is a member of the above Fire Company/Department, has successfully completed all prerequisites listed above and is covered by Workers' Compensation and Liability Insurance.

Name_____ Title _____ Date _____

Signature_____ Phone # _____

Academy Use:

Date Received _____ Received By _____ _____ D.O.B Verified By _____

BOROUGH OF ATLANTIC HIGHLANDS
NJPEOSHA BLOODBORNE PATHOGENS
HEPATITIS B VACCINE RECORD

One section must be completed by all employees exposed or potentially exposed to bloodborne pathogens as defined in the borough of Atlantic Highlands bloodborne pathogens exposure plan.

PRINT ALL INFORMATION EXCEPT WHERE SIGNATURE IS REQUIRED

CONSENT FORM

EMPLOYER:_____ DEPARTMENT:_____

I have read or have had explained to me the information sheet about hepatitis B and hepatitis B vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits & risks of the hepatitis B vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request.

LAST NAME | FIRST NAME | MI. | D.O.B. | AGE | CLINIC I.D.

ADDRESS | CITY | STATE | ZIP

DATE VACCINATED | MANUFACTURER LOT #

SIGNATURE OF PERSON RECEIVING VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST | DATE | SITE OF INJECTION

HEPATITIS B VACCINE DECLINATION

I UNDERSTAND THAT DUE SOME OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS, I MAY BE AT RISK OF ACQUIRING HEPATITIS B VIRUS (HBV) INFECTION. I HAVE BEEN GIVEN THE OPPORTUNITY TO BE VACCINATED WITH THE HEPATITIS B VACCINE, AT NO CHARGE TO MYSELF. HOWEVER, I DECLINE HEPATITIS B VACCINATION AT THIS TIME. I UNDERSTAND THAT BE DECLINING THIS VACCINE I CONTINUE TO BE AT RISK OF ACQUIRING HEPATITIS B, A SERIOUS DISEASE. IF IN THE FUTURE I CONTINUE TO HAVE OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIAL AND I WANT TO BE VACCINATED WITH THE HEPATITIS B VACCINE, I CAN RECEIVE THE VACCINATION SERIES AT NO CHARGE TO ME.

NAME (PRINT) | SIGNATURE | DATE

WITNESS (PRINT) | SIGNATURE | DATE

PREVIOUS HEPATITIS B VACCINATION

I DECLINE HEPATITIS B VACCINATION AT THIS TIME BECAUSE I WAS PREVIOUSLY VACCINATED.

NAME (PRINT) | SIGNATURE | DATE

DATES OF VACCINATIONS: 1._____ 2._____ 3._____

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: **Can you read (circle one): Yes/No**

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year): _____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): _____
_____

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

   a. Seizures (fits): Yes/No
   b. Diabetes (sugar disease): Yes/No
   c. Allergic reactions that interfere with your breathing: Yes/No
   d. Claustrophobia (fear of closed-in places): Yes/No
   e. Trouble smelling odors: Yes/No

3. Have you **ever had** any of the following pulmonary or lung problems?

   a. Asbestosis: Yes/No
   b. Asthma: Yes/No
   c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
   d. Have to stop for breath when walking at your own pace on level ground: Yes/No
   e. Shortness of breath when washing or dressing yourself: Yes/No
   f. Shortness of breath that interferes with your job: Yes/No
   g. Coughing that produces phlegm (thick sputum): Yes/No
   h. Coughing that wakes you early in the morning: Yes/No
   i. Coughing that occurs mostly when you are lying down: Yes/No
   j. Coughing up blood in the last month: Yes/No
   k. Wheezing: Yes/No
   l. Wheezing that interferes with your job: Yes/No
   m. Chest pain when you breathe deeply: Yes/No
   n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No
b. Stroke: Yes/No
c. Angina: Yes/No
d. Heart failure: Yes/No
e. Swelling in your legs or feet (not caused by walking): Yes/No
f. Heart arrhythmia (heart beating irregularly): Yes/No
g. High blood pressure: Yes/No
h. Any other heart problem that you've been told about: Yes/No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No
b. Pain or tightness in your chest during physical activity: Yes/No
c. Pain or tightness in your chest that interferes with your job: Yes/No
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
e. Heartburn or indigestion that is not related to eating: Yes/ No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems: Yes/No
b. Heart trouble: Yes/No
c. Blood pressure: Yes/No
d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No
b. Skin allergies or rashes: Yes/No
c. Anxiety: Yes/No
d. General weakness or fatigue: Yes/No
e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?

    a. Wear contact lenses: Yes/No
    b. Wear glasses: Yes/No
    c. Color blind: Yes/No
    d. Any other eye or vision problem: Yes/No

12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No

13. Do you **currently** have any of the following hearing problems?

    a. Difficulty hearing: Yes/No
    b. Wear a hearing aid: Yes/No
    c. Any other hearing or ear problem: Yes/No

14. Have you **ever had** a back injury: Yes/No

15. Do you **currently** have any of the following musculoskeletal problems?

    a. Weakness in any of your arms, hands, legs, or feet: Yes/No
    b. Back pain: Yes/No
    c. Difficulty fully moving your arms and legs: Yes/No
    d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
    e. Difficulty fully moving your head up or down: Yes/No
    f. Difficulty fully moving your head side to side: Yes/No
    g. Difficulty bending at your knees: Yes/No
    h. Difficulty squatting to the ground: Yes/No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
    j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:_____
_____
_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No
b. Silica (e.g., in sandblasting): Yes/No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
d. Beryllium: Yes/No
e. Aluminum: Yes/No
f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:_____
_____
_____

4. List any second jobs or side businesses you have:_____
_____

5. List your previous occupations:_____
_____

6. List your current and previous hobbies:_____
_____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No
b. Canisters (for example, gas masks): Yes/No
c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No
b. Emergency rescue only: Yes/No
c. Less than 5 hours **per week:** Yes/No
d. Less than 2 hours **per day:** Yes/No
e. 2 to 4 hours per day: Yes/No
f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:_____
_____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):
_____
_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
_____
_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:
_____
_____
_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):