

# MAGNOLIA VOLUNTEER FIRE DEPARTMENT



## Employment Application

For the purpose of establishing my personal record with the Magnolia Volunteer Fire Department, in determining my qualifications and eligibility, I submit the following data:

APPLICANT INFORMATION									
Last Name			First			M.I.	Date		
Street Address						Apartment/Unit #			
City			State			ZIP			
Home Phone		Work Phone			Cell Phone			E-mail	
Birth Date		Age	Sex	Ht.	Wt.	Hair Color		Eye Color	
Social Security #		TX Driver License#			Class		Date Available		
Current Employer				Employer Phone					
Are you a citizen of the United States?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Have you ever worked for MVFD?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?					
Have you ever been convicted of a felony?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain					

PRIOR EXPERIENCE			
Name of Department:	From:	To:	Reason for Leaving?
Name of Department:	From:	To:	Reason for Leaving?
Name of Department:	From:	To:	Reason for Leaving?
Name of Department:	From:	To:	Reason for Leaving?

TRAINING	
<b>Please return completed application with copies of EMS and Texas Fire certifications</b>	
<b>LIST RELEVANT TRAINING IN FIREFIGHTING AND EMS SUBJECT AREAS</b>	
Subject of Training:	Date Completed:
Subject of Training:	Date Completed:
Subject of Training:	Date Completed:
Subject of Training:	Date Completed:
Subject of Training:	Date Completed:

## REFERENCES

Please list three non-related character references.

Full Name	Relationship
Company	Phone ( )
Address	

Full Name	Relationship
Company	Phone ( )
Address	

Full Name	Relationship
Company	Phone ( )
Address	

## MEDICAL QUESTIONNAIRE

YES

NO

IF YES, REMARKS

	YES	NO	IF YES, REMARKS
1. EYESIGHT			
A. Have you lost use of either eye?			
B. Is peripheral (side) vision restricted?			
C. Are you color blind?			
D. Do you have, or have you ever had cataracts?			
E. Are actual deficiencies corrected by glasses or contact lenses? If "No" please explain under "Remarks."			
F. Date of last eye examination			
2. HEARING			
A. Do you have difficulty hearing normal conversation levels?			
B. Do you use a hearing aid?			
3. DIABETES			
A. Have you ever been treated for Diabetes?			
B. Describe current medication and dosage, if any and method of administration under "Remarks."			
C. Date of latest blood sugar test: _____			
4. HEART			
A. Have you ever been treated for heart disease?			
B. Describe condition under "Remarks."			
C. Describe current medication and dosage, if any under "Remarks."			
D. Do you have a pacemaker?			
E. Date of last treatment or check-up: _____			
5. EPILEPSY			
A. Have you ever been treated for Epilepsy?			

B.	If "Yes" when was your last seizure? List in "Remarks."		
C.	Describe current medication and dosage, if any under "Remarks."		
6.	<b>BLOOD PRESSURE</b>		
A.	Have you ever been treated for high blood pressure?		
B.	If "Yes" when were you treated? _____		
C.	What was your last reading? _____		
D.	Describe current medication and dosage, if any under "Remarks."		
7.	<b>LIMBS</b>		
A.	Have you lost the use of an arm or leg?		
B.	Does your vehicle have special controls?		
8.	<b>MISCELLANEOUS</b>		
A.	Have you ever had, or been treated for convulsions?		
B.	If "Yes" give date of last treatment and describe current medication and dosage, in any under "Remarks."		
C.	Have you ever had any fainting spells?		
D.	If "Yes" give the date of last treatment and describe current medications and dosage, if any under "Remarks."		
E.	Have you had, or been treated for, loss of equilibrium?		
F.	Have you ever been treated for alcohol or drug abuse?		
G.	If "Yes" give date of last treatment and describe current medication and dosage, in any under "Remarks."		
H.	Have you ever been treated for mental illness?		
I.	If "Yes" give date of last treatment and describe current medication and dosage, in any under "Remarks."		
9.	What is the date of your last physical examination? _____		
10.	Are there any restrictions posted on your vehicle operator's license? If "Yes" give reason under "Remarks."		
11.	Are you being treated for any conditions not mentioned above which may affect your ability to operate a motor vehicle?		
12.	When and for what purpose, did you last consult a doctor? List under "Remarks."		

**PERSONAL PHYSICIAN (PLEASE PROVIDE FULL NAME, ADDRESS AND PHONE NUMBER)**

FULL NAME	
ADDRESS	
CITY, STATE, ZIP	
PHONE#	

**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature

Date

# MAGNOLIA VOLUNTEER FIRE DEPARTMENT

## CRIMINAL HISTORY CHECK AUTHORIZATION AND INFORMATION FORM

This form is to assist The Magnolia Volunteer Fire Department in conducting a Criminal History Check of all applicants, members, and employees. Please complete all of the Criminal History information requested.

**CONVICTION OF A CRIME IS NOT AN AUTOMATIC BAR TO CONSIDERATION FOR EMPLOYMENT OR CONTINUED EMPLOYMENT, EXCEPT WHERE EMPLOYMENT IS PROHIBITED BY LAW FOR CERTAIN CONVICTIONS; FOR OTHER OFFENSES, FACTORS SUCH AS THE DATE OF THE OFFENSE, THE TIME PERIOD BETWEEN THE OFFENSE AND THE PRESENT, THE NATURE AND SERIOUSNESS OF THE OFFENSE, AND THE REHABILITATION WILL BE CONSIDERED BY THE MAGNOLIA VOLUNTEER FIRE DEPARTMENT.**

### CRIMINAL HISTORY INFORMATION

Applicants for membership and/or employment, and current members of The Magnolia Volunteer Fire Department are requested to provide information on this Criminal History Check Authorization Form. The information provided will be used solely for the purpose of assisting The Magnolia Volunteer Fire Department or its agent in conducting a criminal history check. Failure to provide all of the information requested will result in the rejection of an applicant, or discipline, up to and including termination, of a member or employee.

Last Name		First		M.I.	Date	
Street Address				Apartment/Unit #		
City			State		ZIP	
Birth Date	Age	Sex	Race	Station#	FDID#	
Social Security #		TX Driver License#				
Previous Addresses						

Previous Address (most recent first):

---

Street	City	County	State	Zip	Dates
--------	------	--------	-------	-----	-------

---

Street	City	County	State	Zip	Dates
--------	------	--------	-------	-----	-------

List all Aliases or former names (including maiden names), and dates of use:

