

BERKELEY HILLS FIRE COMPANY

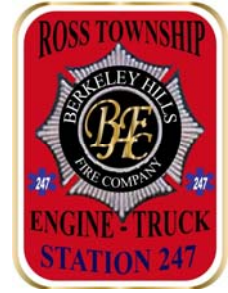
Allegheny County Station 247

235 Siebert Rd. Pittsburgh, Pa. 15237

Phone (412) 366-2910 Fax (412) 847-0631

www.station247.org

Established 1942



Application for Membership

Applicant Information

Full Name (first middle last)					
Street					
City		State		Zip	
Phone	Mobile	Home	Work		
Email address(s)					

Drivers License Num		State		Class	
Restrictions				Expiration	/ /

Social Sec. Num:		Date of Birth	/ /
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Type of Membership

- Firefighter Fire Police QRS Administrative

OFFICE USE

Date of submission	/ /		
Date of interview	/ /	Interviewed by	
Date of Board approval	/ /		
Date of Company approval	/ /		

Emergency Contact Information

Name		Relationship	
Street			
City		State	Zip
Phone	Mobile	Home	

Previous/Current Emergency Service experience

Dates	Organisation				
<p>In order to receive up to ten years credit towards life membership, you must submit documented proof of active fire company membership to the Recording Secretary within six months of membership. Only service prior to becoming a member of Berkeley Hills is eligible for life member credit.</p>					
Firefighter and Medical certifications.					
<input type="checkbox"/> Essentials of Firefighting	<input type="checkbox"/> FF1	<input type="checkbox"/> FF2	<input type="checkbox"/> 1st Resp.	<input type="checkbox"/> EMT	<input type="checkbox"/> Paramedic
Please attach copies of all training certificates.					

Additional Information

Occupation			
Employer			
Supervisor		Phone	

Education	High School:	Dates	
	College:		
	Other:		

List any medical conditions

List any criminal history and traffic violations

Additional Information cont.

Please provide four references other than family members that we can contact.		
Name	Phone	Relationship

List any other special skills

Why you would like to join Berkeley Hills Fire Company?

Statement of Understandings and Authorizations

I hereby apply for membership in the Berkeley Hills Fire Company (hereinafter known as the Company) and, if accepted for membership, I will comply with the bylaws, policies, standard operating guidelines, and the conduct expected of company members.

I authorize the Company to investigate the statements made in this application, I understand that an investigation of these statements may be made, including but not limited to, a criminal background check and a Bureau of Motor Vehicles records check. I understand that omitting or falsifying information in this application or any subsequent interview connected with this application might result in denial of membership or expulsion from the Company.

I hereby authorize the following parties to release any and all information concerning me to the Officers of the Company and their agents:

1. Bureau of Motor Vehicles of the Commonwealth of Pennsylvania, or any other state drivers license authority;
2. Any Law Enforcement Agency;
3. Any emergency services agency I was ever a member of;
4. Any employer, past or present.

Signature of Applicant:

_____ Date: _____

Printed Name: _____

Signature of parent or guardian if applicant is under the age of 18:

_____ Date: _____

Printed Name: _____

Berkeley Hills Fire Company is an equal opportunity Employer and does not discriminate on the basis of sex, race, creed, age or nationality.



Accident & Health Beneficiary Designation Form

Please complete this form and return it with your application. Please do not return this form to Provident.
Please PRINT or TYPE.

Ross Twp Firemen's Relief Assn./Berkeley Hills Fire Co. ESO-5846405
Policyholder Name (Emergency Service Organization) Policy #

Member's Last Name First Initial Date of Birth

Member's Street Address

Members's City State PA Zip Code Social Security #

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Member's Signature Date Signed