COMMISSIONERS OF FIRE DISTRICT No.2

3031 Route 27, Suite 3
FRANKLIN TOWNSHIP, SOMERSET COUNTY, NEW JERSEY
FRANKLIN PARK, N.J. 08823

APPLICATION FOR MEMBERSHIP

Enclosed you will find the forms needed to join Franklin Township Fire District #2.

The following are the Fire Companies in Fire District #2.

Franklin Park Vol. Fire Co.

Griggstown Vol. Fire Co.

Little Rocky Hill Vol. Fire Co.

Please complete all the forms as needed and return to:

Board of Fire Commissioners

Fire District #2

3031 Rt. #27 Suite #3

Franklin Park, New Jersey 08823

List of Forms:

1. Application for Membership
2. Application for Membership (Jr. Firemen's Auxiliary)
3. Background Investigation and Physical Instructions
4. Hepatitis B Vaccine
5. Hepatitis B Release & Indemnification
6. Hepatitis Declination Statement
7. Beneficiary Designation (Accident & Sickness)
9. Beneficiary Designation (Life)

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APPLICATION FOR MEMBERSHIP

Check One Fire Company:

_____ Franklin Park Fire Company _____ Griggstown Fire Company _____ Little Rocky Hill Fire Company

Applying For: ____Firefighter no Previous Training ____Firefighter with Previous Training
____ Jr. Firemen's Auxiliary

Name_____
Last First Middle Initial

_____
Street Address City State Zip Code

_____
Mailing Address City State Zip Code

Driver's License # _____/_____/_____ **SS#** _____/_____/_____

Home Telephone # (____) _____ **Cell Phone# (____)** _____

E-Mail Address _____

D.O.B. ____/____/_____ **Blood Type**_____ **Eye Color**_____

Weight lb. _____ **Hair Color**_____

Point of contact in event of an Emergency _____

Phone (____) _____

Please answer the following questions:

Has your Driver's License been revoked or suspended in the past 3 years? Yes ☐ No ☐
How many points if any on license at time of application _____
Have you ever been convicted of a crime? Yes ☐ No ☐

Do you have any physical limitations that would restrict your activities as a firefighter? Yes ☐ No ☐
(If you answered "YES" to any of the above questions, please attach a brief explanation on a separate sheet)

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that inaccurate or falsified statements on this application shall be grounds for rejection and/or immediate dismissal from the Fire District. I authorize investigation of all statements contained herein. I understand that if applying for firefighter, I must pass a medical exam in order to become a probationary firefighter; failure will be grounds for immediate dismissal.

SIGATURE: _____ **DATE:** _____

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APPLICATION FOR MEMBERSHIP
JR. FIREMEN'S AUXILIARY

Name_____
Last **First** **Middle Initial**

Street Address_____ **Phone**_____

Mailing Address_____

D.O.B. _____ **Occupation** _____ **SS #**_____ / _____ / _____

Length of Time at Present Address_____

Parent's Business Address _____ **Phone**_____

Point of Contact in event of an Emergency _____ _____
Name **Phone**

New Jersey Statutes – Title 40A Municipalities and Counties – Section 40A: 14-96, in part: "Such permission shall be in writing and acknowledged or proved in the manner required by law for deeds to real estate to be recorded."

Signature_____ **Date**_____

Sponsor_____

For applicants under the age of 18:

I hereby give permission for my son/daughter_____
to join Fire district #2 as a Junior Member.

Print Name _____ **Signature**_____
(Parent or Legal Guardian)

Date _____

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Please Read Carefully

If the applicant is applying as a Firefighter with Previous Training, the applicant will be sent for a physical and background check. If the applicant is applying as a Firefighter with No Previous Training the applicant must at least attend four (4) schedule station events consecutively before the applicant can go for a physical and background check. This will ensure that the applicant is sincere in joining the District.

Background check Instructions

1 You ***must*** *fill* the following information:

2. Applicant Name. _____

3. Phone number. _____

4. Email address. _____

Physical Instructions

1 Please contact Sandy at 732-422-6744 ext. 102 with your preferred medical facility. Sandy will email/mail out the proper medical forms:

_____Access Compliances, 622 Georges Road, North Brunswick, NJ

_____Central Jersey Urgent Care, 84 Veronica Avenue, Somerset, NJ

_____Private Physician.

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HEPATITUS B VACCINE

I have read or have had explained to me the information on hepatitis B and hepatitis B vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the hepatitis B vaccine and request that it be given to me.

As with all vaccines, immunity to Hepatitis B is not guaranteed.

Please Print

Member's Name _____
Last First M.I.

_____
Street Address City State Zip Code

_____
Mailing Address City State Zip Code

_____ _____ _____/_____/_____
Date of Birth Age Social Security #

_____
Date

_____ _____
Print Name: Signature of person to receive vaccine or parent or guardian

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Appendix B3

HEPATITIS B

RELEASE AND INDEMNIFICATION

I agree to indemnify and save harmless the Commissioners of Fire District #2 in the Township of Franklin, County of Somerset for any damages that might or do occur in connection with my receiving Hepatitis B Vaccine as part of a Board of Fire Commissioners sponsored project, to the extent permitted by law. Moreover, I understand that the vaccinations consist of a series of three injections, and without all of the vaccinations those received will not be effective. For that reason, not only do I release the Board from liability with respect to any failure on my part to receive all of the scheduled vaccinations, but I also agree that I will reimburse the Board for the cost of the vaccinations given if I do not complete the series of all three. I acknowledge being informed that the protection furnished by the vaccine will last approximately seven years. I have been warned that there are possible side effects from the vaccinations, the most common of which is soreness from the injection, and I further acknowledge that I have been told to ask my doctor if I have any questions.

Members Name: _____
Last First M.I.

_____
Street Address City State Zip

_____
Date

_____ _____
Print Name: Signature of person to receive vaccine

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IMPORTANT INFORMATION ABOUT HEPATITIS B AND HEPATITIS B VACCINE

PLEASE READ CARFULLY

WHAT IS HEPATITIS B?

Hepatitis b is an infection of the liver caused by the hepatitis B virus (HBV). The term "viral hepatitis" is often used for and may include hepatitis B and other similar diseases, which affect the liver but are caused by different viruses. Acute hepatitis generally begins with mild symptoms that may or may not become severe. These symptoms may include loss of appetite, a vague feeling of oncoming illness, extreme tiredness, nausea, vomiting, stomach pain, dark urine, and jaundice (yellow eyes & skin). Skin rashes and joint pain can also occur.

In the U.S. about 300,000 people's mostly young adults, catch Hepatitis B each year. About one-fourth will develop jaundice, and more than 10,000 will need to be hospitalized. About 250 people die each year from severe acute hepatitis B. Between 6 and 10 of every 100 young adults who catch hepatitis B become chronic carriers (have HBV in their blood for 6 or more months) and may be able to spread the infection to others for a long period of time. Infants who catch hepatitis B are more likely to become carriers than adults are. About one-forth of these carriers go on to develop a disease called "chronic active hepatitis." Chronic active hepatitis often causes cirrhosis of the liver (liver destruction) and death due to liver failure. In addition, HBV carriers are much more likely than others to get cancer of the liver. An estimated 4,000 persons die from hepatitis B-related cirrhosis each year in the U.S. and more than 800 die from hepatitis B-related liver cancer.

The risk of catching hepatitis is higher In certain groups of people because of their occupation, lifestyle, or environment. Because of the risks of serious problems associated with hepatitis B infection, vaccinations to help prevent infections are recommended for these groups.

HEPATITUS B VACCINE:

Recombinant Hepatitis B vaccines are made from common baker's yeast cells through genetic engineering. The yeast-derived vaccines do not contain human blood products. The vaccine is given by injection on 3 separate dates. Usually, the first 2 doses are given 1 month apart, and the third dose, 5 months after the second. After 3 doses, the hepatitis B vaccine is 85%-95% effective in preventing hepatitis B infection in those who received the vaccine. Protection for normal healthy adults given the vaccine lasts at least 7 years. Booster doses of vaccine are not routinely recommended at the present time.

WHO SHOULD GET HEPATITUS B VACCINE?

The vaccine is recommended for persons at high risk of catching HBV infection who are or may be unprotected.
These groups include:

1. Persons with occupational risk. Health care and public safety workers who are exposed to blood or blood products or who may get accidental needle sticks should be vaccinated.

2. Clients and staff of institutions for the developmentally disabled. The special behavioral and medical problems of these persons make this a high-risk setting. Risk in institutions is related to contact with blood and also with bites and contacts with skin lesions and other body fluids that contain HBV. Clients and staff of group and foster homes where a carrier is known to be present should also be vaccinated

3. Hemodialysis patients. Although the hepatitis B vaccine is less effective in those patients, it should still be offered to all hemodialysis patients. Higher doses and/or special preparations are required for these persons.

4. Homosexually active men.

5. Users of unlawful inject able drugs. Sharing needles is an extremely high-risk actively for transmitting hepatitis B.

6. Recipients of certain blood products. Persons such as hemophiliacs who receive special products to help their blood clot are at high risk of infection

7. Household and sexual contacts of HBV carriers. When HBV carriers are identified, household and sexual contacts should be offered vaccine.
8. Adoptees from countries with high rates of HBV infection. Families with orphans or unaccompanied minors from such countries should have the child checked for HBV carriage, and, if positive, family members should be vaccinated.
9. Other contacts of HBV carriers. Vaccine use should be deinstitutionalized developmentally disable HBV carriers behave aggressively or have special medical problems that may expose contacts to their blood or body secretions. Teachers and aides have been shown to be at significant risk in these settings. Other persons who have casual contact with carriers at schools and offices are at little risk of catching HBV infection and vaccine is not recommended for them.
10. Special populations from areas with high rates of hepatitis B. These groups include Alaskan natives, native Pacific islanders, immigrants and refugees from eastern Asia and sub-Saharan Africa, and their U.S. born children.
11. Inmates of long-term correctional facilities. The risk of inmates catching HBV may be due to use of unlawful inject able drugs and male homosexual practices.
12. Heterosexuals who come in for treatment of other newly acquired sexually transmitted diseases who have histories of sexual activity with multiple sexual partners in the past 6 months.
13. Persons who plan to travel to areas outside the U.S. that have high risks of hepatitis B infection, stay in these areas for more than 6 months, and have close contact with the local population; and, persons traveling for shorter durations who may have contact with blood from or sexual contact with local persons in arrears where HBV infection is common. Persons traveling abroad who will perform medical procedures in areas where HBV infection is common are at very high risk.
14. Persons who have contact with potentially infected blood or body fluids.

CONTRAINDICATION:
Hypersensitivity to yeast or any other component of the vaccine.

POSSIBLE SIDE EFFECTS FROM THE VACCINE:
The most common side effect are soreness, redness, and swelling at the site of the injection. Other mild local and systemic side effects have been reported. Illnesses, such as neuralgic reactions, have been reported after vaccine is given, but hepatitis B vaccine is not believed to be the cause of these illnesses. As with any drug or vaccine, there or is a rare possibility that allergic or more serious reactions or even death could occur. No deaths, however, have been reported in persons who have received the vaccine. Giving hepatitis B vaccine to persons who are already immune or to other carriers will not increase the risk of side effects.

PREGNANCY:
No information is available about the safety of the vaccine for unborn babies; however, because the vaccine contains only particles that do not cause hepatitis B infection, there should be no risk. In contrast, if a pregnant woman gets hepatitis B infection, this may cause severe disease in the mother and chronic infection in the newborn baby. Therefore, pregnant woman who are otherwise eligible can be given hepatitis B vaccine, only if clearly needed.

Questions:
If you have any questions about hepatitis B or hepatitis B vaccine, please ask us now or call your doctor or health department before you sign this form.

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CONFIDENTIAL

DECLINATION STATEMENT

Hepatitis B Vaccine

***Please check appropriate box*:**

☐ I understand that due to my 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 hepatitis b vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by 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 materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I am declining the vaccination because I have already received my hepatitis B vaccination from _____ on or about the following date: _____. I also have taken part in a blood borne pathogens awareness course given by: _____on or about the following date: _____.

Date: _____

_____ _____

Print Name: Signature

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Volunteer Fireman's Insurance services, Inc.

Beneficiary Designation for Accident & Sickness Policy

Please Print

Member's Name _____
Last First Middle Initial

Member's Date of Birth _____

Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary

I hereby designate the following beneficiary (ies) with respect to amounts payable as indemnity for loss of life Under the referenced Accident& Sickness Policy and hereby revoke any designation of beneficiary there under heretofore made by me. I direct that any amounts payable under said Policy to my beneficiary (ies) named below Be paid to those of Primary Beneficiary whom survive me. Otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary

Beneficiary:

Name _____ Relationship _____ Date of Birth _____ Share____%

Name _____ Relationship _____ Date of Birth _____ Share____%

Contingent

Beneficiary:

Name_____ Relationship_____ Date of Birth _____ Share ____%

Name _____ Relationship _____ Date of Birth _____ Share____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made to my estate. I reserve the right to revoke or change this designation.

Signature_____ ***Date*** _____

This form will be retained in the files of Fire District #2, reviewed, and updated on a regular basis.

COMMMISSIONERS OF FIRE DISTRICT No.2

3031 Route 27, Suite 3
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FRANKLIN PARK, N.J. 08823

Volunteer Fireman's Insurance services, Inc.

Beneficiary Designation for Life Insurance Policy

Please Print

Member's Name _____
Last First Middle Initial

Member's Date of Birth _____

Date Member Joined Organization _____

Social Security Number _____ / _____ / _____

After all of the above information has been completed, Please SIGNED and DATED by the member.

Signature _____ ***Date*** _____

This form will be retained in the files of Fire District #2, reviewed, and updated on a regular basis.

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800) 233-1957 or (717) 741-0911
www.vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐ _____ **Policyholder** Comm of Fire District #2 **Policy Number** CVT301509R

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ _____ **Policyholder** _____ **Policy Number** _____

☐ **Other** _____

☐ **Other** _____

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Date of Membership:**	**Social Security Number:** / /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class ☐ **Mark if additional beneficiaries are listed on a separate paper and attached.** **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ SIGN HERE Date: _____

Sample wording for Beneficiary Designations

Class	Relationship to Insured	Percent
One Beneficiary of a class Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.