Lower Macungie Fire Department

Membership Application

Date

Last Name | First Name | Middle Int.

Primary Phone: H W M | Phone 2: H W M | Phone 3: H WM | E-Mail

Circle One: H = Home / W =Work/ M = Mobile

Address:

Street

City | State | Zip

Date of Birth | Social Security Number

Driver's License Number | State | Class

EMS Certified (Circle One): Y N | EMS Certification Number | Expires

Sex (Circle One): M F

Emergency Contact Information:

Name

Primary Phone Number | Alternate Phone Number

Beneficiary | Date

Previous Fire/EMS Experience:

Mailing Address
P.O. Box 3002
Wescosville, PA 18106
(610) 398-0996

One department three stations
Alburtis
Brandywine
Wescosville
www.firestation30.org

LOWER MACUNGIE FIRE DEPARTMENT

OSHA BLOODBORNE PATHOGEN STANDARD

HEPATITIS B IMMUNIZATION CONSENT / WAIVER FORM

Member Name:_____ **Birthday:**_____

I have been informed of my agency's Bloodborne Pathogens Practice Standard and the Hepatitis B Vaccine Program and;

1. I understand that a series of three (3) injections of Hepatitis B vaccine is required to provide protection (occasionally, more vaccine is needed if the first series does not result in immunity)

2. If I do not become protected from receiving the vaccine, or if I choose not to receive the vaccine at this time, I understand that I will need post-exposure treatment if I have direct contact with blood or other body fluids at work.

3. 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 vac cine, 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 have read and I understand the above information and WISH TO RECEIVE the Hepatitis B vaccine series (three doses). Also, I have no known sensitivity to yeast.

SIGNATURE: _____ DATE:_____

I have read and I understand the above information and DO NOT WISH TO receive the Hepatitis B vaccine (three doses) at this time, Or already have had the vaccine.

SIGNATURE: _____ DATE:_____

DATE OF VACCINE (to the best of knowledge): _____

READ FIRST

LMFD applicants only need to complete the two lines marked with arrows below

SP 4-164 (12-2017)

PENNSYLVANIA STATE POLICE

REQUEST FOR CRIMINAL RECORD CHECK

1-888-QUERYPA (1-888-783-7972)

This form is to be completed in ink by the requester – (information will be mailed to the requester only). If this form is not legible or not properly completed, it will be returned unprocessed to the requester. *A response may take four weeks or longer.*

TRY OUR WEBSITE FOR A QUICKER RESPONSE
https://epatch.state.pa.us

REQUESTER NAME	
ADDRESS	
CITY/STATE/ ZIP CODE	
TELEPHONE NO. (AREA CODE)	

FOR CENTRAL REPOSITORY USE ONLY
CONTROL NUMBER

AFTER COMPLETION MAIL TO:

PENNSYLVANIA STATE POLICE
CENTRAL REPOSITORY – 164
1800 ELMERTON AVENUE
HARRISBURG, PA 17110-9758

DO NOT SEND CASH OR PERSONAL CHECK

CHECK ONE BLOCK

☐ INDIVIDUAL/NONCRIMINAL JUSTICE AGENCY – ENCLOSE A CERTIFIED CHECK/MONEY ORDER IN THE AMOUNT OF $22.00, PAYABLE TO: "*COMMONWEALTH OF PENNSYLVANIA*"
THE FEE IS NONREFUNDABLE

☐ NOTARIZED INDIVIDUAL/NONCRIMINAL JUSTICE AGENCY – ENCLOSE A CERTIFIED CHECK/MONEY ORDER IN THE AMOUNT OF $27.00, PAYABLE TO: "*COMMONWEALTH OF PENNSYLVANIA*"
THE FEE IS NONREFUNDABLE

☐ FEE EXEMPT-NONCRIMINAL JUSTICE AGENCY – NO FEE

SUBJECT OF RECORD CHECK

(FIRST)	(MIDDLE)	(LAST)		
MAIDEN NAME AND/OR ALIASES	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	SEX	RACE

The Pennsylvania State Police response will be based on the comparison of the data provided by the requester against the information *contained in the files of the Pennsylvania State Police Central Repository only.*

FEES FOR REQUESTS - $22.00. NOTARIZED FEE REQUESTS - $27.00.
***MAKE ALL MONEY ORDERS PAYABLE TO: *COMMONWEALTH OF PENNSYLVANIA* ***

REASON FOR REQUEST

◄◄◄◄◄◄CHECK THE BOX THAT MOST APPLIES TO THE PURPOSE OF THIS REQUEST►►►►►►

☐ **INTERNATIONAL ADOPTION** - INTERNATIONAL ADOPTION MUST BE NOTARIZED AND MAILED IN. ($27.00 FOR REQUEST)

☐ ADOPTION (DOMESTIC) ☐ EMPLOYMENT ☐ VISA ☐ OTHER

WARNING: 18 Pa.C.S. 4904(b) UNDER PENALTY OF LAW - MISIDENTIFICATION OR FALSE STATEMENTS OF IDENTITY TO OBTAIN CRIMINAL HISTORY INFORMATION OF ANOTHER IS PUNISHABLE AS AUTHORIZED BY LAW.

Homeland Security is Everyone's Responsibility - Pennsylvania Terrorism Tip Line 1-888-292-1919

Pennsylvania Voluntary Fire Service

Act 168 Form

Act 168 of 2006 amended Title 18 (Crimes and Offenses) of the Pennsylvania Consolidated Statutes, Section 2, subsection (h) (1) Arson and related offenses reads:

"A person convicted of violating this section or any similar offense under Federal or State law shall be prohibited from serving as a firefighter in this Commonwealth and shall be prohibited from being certified as a firefighter under Section 4 of the Act of November 13, 1995 (P.L. 604, No.61), known as the State Fire Commissioner Act."

All individuals making application for certification testing must provide documentation of a background check. Proof of a non-conviction MUST consist of either of the following:

1. An official criminal history record check obtained pursuant to Chapter 91 (relating to criminal history record information) indicating no arson convictions.

OR

2. By dating and signing of the following statement by the person swearing to the following:

"I have never been convicted of an offense that constitutes the crime of "arson and related offenses" under 18 Pa. C.S 3301 or any similar offense under any Federal or State law. I hereby certify that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to penalties prescribed by law, including, but not limited to, a fine of at least $1,000.00"

_____

Signature of Responder

_____ _____

Name of Responder (please print or type) Date

DISCLOSURE STATEMENT APPLICATION FOR VOLUNTEERS
Required by the Child Protective Service Law
23 Pa. C.S. Section 6344.2 (relating to volunteers having contact with children)

I swear/affirm that I am seeking a volunteer position and **AM NOT** required to obtain a certification through the Federal Bureau of Investigation (FBI), as:

- the position I am applying for is unpaid; **and**
- I have been a resident of Pennsylvania during the entirety of the previous ten-year period.

I understand that if I have not been a resident of Pennsylvania during the entirety of the pervious ten-year period, but have received certification from the FBI since establishing residency, I must provide a copy of the certification to my employer and am not required to obtain any additional FBI certifications.

I swear/affirm that, if providing certifications that have been obtained within the preceding 60 months, I have not been disqualified from service as outlined below or have not been convicted of an offense similar in nature to a crime listed below under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of this Commonwealth.

I swear/affirm that I have not been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

I swear/affirm that I have not been convicted of any of the following crimes under Title 18 of the Pennsylvania consolidated statutes or of offenses similar in nature to those crimes under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of this Commonwealth.

Chapter 25	(relating to criminal homicide)
Section 2702	(relating to aggravated assault)
Section 2709.1	(relating to stalking)
Section 2901	(relating to kidnapping)
Section 2902	(relating to unlawful restraint)
Section 3121	(relating to rape)
Section 3122.1	(relating to statutory sexual assault)
Section 3123	(relating to involuntary deviate sexual intercourse)
Section 3124.1	(relating to sexual assault)
Section 3125	(relating to aggravated indecent assault)
Section 3126	(relating to indecent assault)
Section 3127	(relating to indecent exposure)
Section 4302	(relating to incest)
Section 4303	(relating to concealing death of child)
Section 4304	(relating to endangering welfare of children)
Section 4305	(relating to dealing in infant children)
Section 5902(b)	(relating to prostitution and related offenses)
Section 5903(c) (d)	(relating to obscene and other sexual material and performances)
Section 6301	(relating to corruption of minors)
Section 6312	(relating to sexual abuse of children), or an equivalent crime under Federal law or the law of another state.

I swear/affirm that I have not been convicted of a felony offense under Act 64-1972 (relating to the controlled substance, drug device and cosmetic act) committed within the past five years.

I understand that I shall not be approved for service if I am named as a perpetrator of a founded report of child abuse within the past five (5) years or have been convicted of any of the crimes listed above or of offenses similar in nature to those crimes under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of this Commonwealth.

I understand that if I am arrested for or convicted of an offense that would constitute grounds for denying participation in a program, activity or service under the Child Protective Services Law as listed above, or am named as perpetrator in a founded or indicated report, I must provide the administrator or designee with written notice not later than 72 hours after the arrest, conviction or notification that I have been listed as a perpetrator in the Statewide database.

I understand that if the person responsible for employment decisions or the administrator of a program, activity or service has a reasonable belief that I was arrested or convicted for an offense that would constitute grounds for denying participation in a program, activity or service under the Child Protective Services Law, or was named as perpetrator in a founded or indicated report, or I have provided notice as required under this section, the person responsible for employment decisions or administrator of a program, activity or service shall immediately require me to submit current certifications obtained through the Department of Human Services, the Pennsylvania State Police, and the Federal Bureau of Investigation, as appropriate. The cost of certifications shall be borne by the employing entity or program, activity or service.

I understand that if I willfully fail to disclose information required above, I commit a misdemeanor of the third degree and shall be subject to discipline up to and including denial of a volunteer position.

I understand that certifications obtained for the volunteering purposes can only be used for that purpose and cannot be used for employment purposes.

I understand that the person responsible for employment decisions or the administrator of a program, activity or service is required to maintain a copy of my certifications.

I hereby swear/affirm that the information as set forth above is true and correct. I understand that false swearing is a misdemeanor pursuant to Section 4903 of the Crimes Code.

Name: _____Signature:_____

Witness: _____Signature:_____

Date: _____

LOWER MACUNGIE FIRE DEPARTMENT

SERVICE AWARD PROGRAM BENEFICIARY DESIGNATION FORM

Please read all instructions carefully before completing this form to ensure proper designation of your beneficiaries.

This form is intended for naming or changing your beneficiary. Any death benefit from the Service Award Program will be made payable in accordance with the designation provided below. This information will be relied upon to contact the individual(s) in the event that a death benefit is payable. Please keep a copy of this form *for* your records and complete a new form if any of the information needs to be updated or changed. Please consult with an attorney before naming a minor or your estate as a beneficiary; typically, death benefits cannot be paid directly to a minor. Please complete this form and return it to the sponsoring municipality *or* volunteer organization.

DATE JOINED: _____

PARTICIPANT INFORMATION

_____ _____ _____ _____

Full Name (First, MI, Last) **Social Security No.** **Date of Birth** **Phone Number/ E-mail**

_____ Lower Macungie Fire Department

Mailing Address **City** **State** **Zip** **Fire Company**

BENEFICIARY DESIGNATION

Death benefits are paid in entirety to the surviving primary beneficiaries. Benefits are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. Unless percentages *are* indicated, death benefits will be made payable in equal amounts. If a beneficiary listed is deceased, the corresponding benefit will be made payable to the remaining beneficiaries within that designation, proportional to the original percentages allocated. If more space is needed, please attach an additional form and label it "Addendum".

PRIMARY

Share (%)	Full Name	Relation	Social Security No.	Date of Birth	Mailing Address
_____ %	_____	_____	_____	_____	_____
_____ %	_____	_____	_____	_____	_____
_____ %	_____	_____	_____	_____	_____

CONTINGENT

Share (%)	Full Name	Relation	Social Security No.	Date of Birth	Mailing Address
_____ %	_____	_____	_____	_____	_____
_____ %	_____	_____	_____	_____	_____
_____ %	_____	_____	_____	_____	_____

PARTICIPANT AND WITNESS SIGNATURES

I hereby name the individuals above as my beneficiaries and declare that this designation supersedes all previous designations.

_____ _____

Participant Signature Date

_____ _____

Witness Signature Date

Witness must be a Notary, *or* an Official of the Fire Department

VFIS
Beneficiary Designation For Accident & Sickness Policy

Complete this block each time this form is used – Please Print

*See back for important **"beneficiary designation information"** and **instructions***

SECTION A:

Department Name _____ **Policy # : VFP** _____

Name of Insured: _____

Address: _____

City/Town: _____ **Postal Code:** _____

Telephone Number: _____ **Date of Birth:** _____

Email: _____

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

SECTION B:

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced **Accident & Sickness Policy for both the on duty and 24 hour and hereby revoke any designation of beneficiary thereunder 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 who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.**

Primary Beneficiary: ***Please read special note on back regarding "minor age children" (you can have more than two people***

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:** _____**%**

Trustee for Minor Children

Name: _____ **Relationship:** _____ **Date of Birth:** _____

If none of the above-named beneficiaries are living at the time of my death, I direct that payments be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature_____**Date**_____

Mail TO: JP Financial Ltd

64 Brookland St Sydney,
NS, B1P 5B2
902 567 3995

Important Beneficiary Information

A. Your policy of coverage contains the following provisions for "Payment of Claim to Beneficiaries".

"Payment of Claims: Any loss of life benefit will be paid in accordance with the beneficiary designation on record with us or the **Policyholder.** If no beneficiary is named, loss of life benefits will be paid to the first surviving class of the following classes: the **Insured Person's** (1) spouse; (2) child(ren); (3) parents; or (4) brothers or sisters. Otherwise, we will pay the benefits to the **Insured Person's** estate.

B. Important Warning: RE: Designating Minor Age Child(ren) as Beneficiaries

Children who are of minor age should **NEVER** be named directly as the beneficiary of insurance proceeds. .***REASON:*** Children are not legally entitled to give the insuring company "Good Discharge" for the contract proceeds. Therefore if you wish to name insurance proceeds to a minor child, you must leave the monies in-trust for the child. You may do this in one of three ways;

1) Leave the monies to a person in-trust for the child or children. Example, "Jane Doe in trust for Emily Deer and Jason Deer". However we suggest you also provide to the trustee, a "letter of direction. This letter should provide the trustee with directions on how this money should be used to benefit the child(ren) while they are minors and at what age and how the proceeds are to be distributed to the child(ren).
2) Leave the monies to your estate but provide within your will for the set up of a trust, specify the policy and what amount of the proceeds you wish to give to the trust for the children.
3) Set up a trust outside your will and name the trust as beneficiary of the insurance proceeds.

We strongly suggest that in all cases you seek advice from your professional advisor on this matter.

C. **Primary Beneficiary:** This is the person(s) who at your death you want to receive some or all of the insurance proceeds. The amount of proceeds you wish to assign to each named beneficiary is expresses as a percentage of the total death benefit payable.

Example: If the sum is $100,000 and you want to give two (2) people $50,000 each then show;
NAME 50%
NAME 50%

D. **Contingent Beneficiary:** This provision names alternative person(s) to receive the insurance proceeds if one or more of the primary beneficiaries have pre-deceased you. The contingent beneficiaries share what proceeds which still remain after the primary beneficiaries have been satisfied according to your designation. This commonly comes into effect when a spouse is named as a primary beneficiary but who dies at the same time as the insured.
NOTE: If no Contingent beneficiary is named and all primary beneficiaries are deceased then the proceeds will be paid as per the contract provision. If you do not want this to occur, name your "Estate" as a Contingent Beneficiary and the proceeds will be distributed under your will.

Instructions

1. Complete all items in Section A. Your "Date of Birth" is our method of identification between persons with the same or similar name.
2. Complete the items you deem important in Section B
3. In Section c, indicate which of the following coverages you wish to have this designation applied:
   Both "On duty and "24 Hour" Coverages
4. Please sign and date this designation

NOTE THE FOLLOWING:

a) The most currently dated document on file will apply.
b) If no designation is on file then the contract provision identified above under item "A" will apply.

To make a change to your designation, complete a new form and submit it to us. Upon receipt of your change request, we will destroy the old designation and confirm to you of your new designation.

To: Lower Macungie Fire Department

I,_____request not to participate in the
Printed Name of Firefighter

Lower Macungie Fire Department Service Award Program. I understand that by signing below I permanently waive all rights to all Service Award Program service credit and cash benefits that I or my heirs may have otherwise been entitled to receive as a result of my active volunteer firefighter service for the Lower Macungie Fire Department. I also understand that I can withdraw this request at any time by properly completing, executing and then submitting to the LMFD Board of Directors a letter requesting to WITHDRAWAL the previously submitted PARTICIPATION WAIVER FORM, and that I would then be eligible to participate in said Service Award Program and that I and my heirs may be entitled to earn Service Award Program service credit and cash benefits from said Service Award Program derived only from my active 'firefighter service after the date such letter is received by the Board of Directors of the Lower Macungie Fire Department.

_____ _____
Signature of Firefighter Date Signed •

Accepted by the Lower Macungie Fire Department on:

_____ _____ _____
Date Print Name Title

_____
Signature

Benefits of Membership

- **Fitness Program** – The department will reimburse you for half of an annual gym membership, up to a cost of $300, provided that you meet the 33% requirement.

- **Holiday Banquet and Summer Picnic –** You will have free entry to the department's holiday banquet in December and a summer event (picnic, Iron Pigs game, etc.) provided that you meet the 33% requirement. (You are exempt from the 33% requirement for these events during the year that you joined.)*

- **Incentive Program** – Our firefighters are paid for each call or Wednesday night training they attend during the year. The amount earned for each event varies from member to member and is based on the certifications / qualifications you hold. This money is paid in January for the prior year, provided that you met the 33% requirement for that year.

- **Retirement Program –** The fire department contributes money annually to a retirement fund for each firefighter. There is a fixed amount contributed each year and it is divided between members based on their length of service. You must meet the 33% requirement to receive a contribution for the year. You are vested after 5 years of participation (5 years of meeting the 33% requirement and receiving a contribution).

- **College Scholarship** – The LMFD Women's Association awards a scholarship for individuals graduating high school who are either the child of a department member or are a member themselves.

- **Annual Physical** – The department will provide an annual physical at no cost. This includes an annual cholesterol test and a chest x-ray and EKG every three years.

- **Commercial Driver's License** – The department will pay for you to obtain your Class B commercial driver's license, and will reimburse you for the difference between the renewal cost of a CDL and the renewal cost of a normal driver's license when you renew your license.

- **Training** – The department will pay for all fire training classes you need (or elect) to take for your service in the department, as long as you have it approved by the Training Officer. The department will also reimburse you for mileage when traveling to training classes.

- **** 33% Requirement –*** *It is necessary to maintain a minimum level of participation throughout the year to be eligible for many of the benefits that the department provides. You receive an attendance credit for each fire call, Wednesday night training, or other department event (work detail, outside class, etc.) you attend. The minimum number of attendance credits necessary to meet the 33% requirement is calculated as 1/3 of the total number of "required" events (fire calls and Wednesday night trainings) that have occurred. This is calculated on a year to date basis.*