Dunn's Corners Fire Department

Serving Westerly & Charlestown Since 1942

Volunteer Membership Application Instructions

Dear Applicant,

Thank you for applying for volunteer membership in the Dunn's Corners Fire Department (DCFD)! We look forward to working with you in one of the best volunteer fire rescue services in the state. Becoming a member of our department is a 4 step process and is easy to complete.

- First, complete and return the Membership Application Package that's attached to this letter.
- Next, you will be asked to meet with our Membership Committee to discuss your application, explain the requirements of being a member in our department and answer any of your questions.
- Then your membership application will be put to a vote to the DCFD membership at one of our monthly meetings for member ratification.
- Lastly, you will be assigned a Lieutenant, a mentor, and an Applicant Training Program packet that will bring you up to speed with the basic skills to be functional and safe.

Membership Application Package:

1. Application Form: Fill out this form completely and sign. If you are unsure about your response to a question, leave it blank and the DCFD Membership Committee will review it with you during your interview.

2. Westerly Police Department BCI Form: All applicants over the age of 18 years must complete a Criminal Background Check with the Westerly Police Department. Fill out the BCI form, have it certified by the police department and return it with your application form. You may also ask the membership committee for assistance if you cannot obtain one in a timely manner.
   a. Westerly Police BCI Hours: Monday & Thursday 9am- 1pm, Wednesday 4-8pm
   b. If you have any out of state convictions, you must get the BCI from that state and bear the cost of that BCI.

3. Medical Clearance: All applicants need to have their medical provider complete the medical form attached. This form helps us keep you safe and allow you to participate within the limits of your abilities. This WILL NOT preclude you from becoming a member. Once you are a member, you will receive a free, annual, department sponsored physical meeting NFPA 1852 standards.

4. VFIS Beneficiary Form: As a member you are automatically covered under an accident and sickness program, of which you need to identify a beneficiary. Keep the brochures at the end.

Once you have completed ALL 4 parts of the Membership Application Package, please drop it off or mail it to us at Dunn's Corner Fire Department, 1 Langworthy Road, Westerly, RI 02891.

Sincerely yours,
The Membership Committee
Dunn's Corners Fire Department

Dunn's Corners Fire Department

Serving Westerly & Charlestown Since 1942

Membership Application

Today's Date: ___/___/____

Name: First:_____ MI:___ Last:_____ DOB: ___/___/____

Address:_____

Phone: _____ Cell Carrier: _____ Email:_____

Driver's License: State_____#_____Class_____Exp_____

Height_____ Weight_____ Allergies_____

EMT # _____ Exp_____ CPR Exp_____

Emergency Notification

Name:_____ Phone (day): _____ Phone (evening): _____
Address: _____
Relationship: _____

Fire Service Background:

Do you have any previous fire/rescue related experience? **Yes** ☐ **No** ☐

Dept: _____ Phone: _____

Details:_____

Training/Certifications (Firefighters/Rescue, EMS, etc. – please include copies of all certificates/licenses)

☐ **Firefighter I** ☐ **Firefighter II** ☐ **CPR/AED** ☐ **First Responder** ☐ **EMT** ☐ **HazMat Ops**

Others:

1. _____
2. _____
3. _____
4. _____
5. _____

Education:

Highest Level of Formal Education Achieved: _____

Personal Reference: Relationship_____
Name_____ Phone_____

Professional Reference: Relationship_____
Name_____ Phone_____

Station # 1
1 Langworthy Road
Westerly, R.I.
02891

www.dunnscornersfire.com
Tel: (401) 322-0577
Fax: (401) 322- 9304

Station #2
5664 Post Road
Charlestown, R.I.
02813

Dunn's Corners Fire Department

Serving Westerly & Charlestown Since 1942

Applicant Name:_____

Background Investigation:

Have you ever had your Driver's License revoked or suspended? **Yes** ☐ **No** ☐
Have you ever been disabled from a job? **Yes** ☐ **No** ☐
(If yes to any of the above, please attach letter outlining the circumstances and outcome)

General Release:

Know all men, than I _____, of the Town of _____, do hereby authorize the Dunn's Corners Fire Department, its agents and employees to obtain the following information about me:

1. Driver's License Check
2. EMT License Check
3. Criminal Background Check

I hereby authorize any agency, organization or person in possession of such information about me, to release said information to Dunn's Corners Fire Department and agree to release the Town of Westerly, Dunn's Corners Fire District and/or the Westerly Police Department, its officers, agents, and employees, and any organization, agency or person providing such information from any liability resulting from an investigative background check for the position of Volunteer Fire Fighter of the Dunn's Corners Fire Department.

Signature:_____ **Date:**_____
If under 18, a parent/guardian signature is required and applicant must contact Chief DeGrave.

Acknowledgement:

I hereby certify that, to the best of my knowledge, all of the information in the application is true and complete. I hereby give consent to the Dunn's Corners Fire Department and its representatives to verify this information by any means. I understand that if I am accepted for membership in the Dunn's Corners Fire Department and this information is subsequently found to be incomplete or inaccurate, I could be subject to disciplinary action and/or expulsion from the department. Additionally, upon resignation/termination of my membership, I will return any and all Dunn's Corners Fire Department/District property in my possession.

Signature_____ Date___/___/_____
Printed_____

Official Use Only

Application Received ___/___/_____	Who Received _____		
Committee Reviewed ___/___/_____	ACCEPT	REJECT	TABLE
Back Ground Check ___/___/_____	ACCEPT	REJECT	TABLE
Interview ___/___/_____	ACCEPT	REJECT	TABLE
Body Meeting ___/___/_____	ACCEPT	REJECT	TABLE

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Tel: (401) 322-0577
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Station #2
5664 Post Road
Charlestown, R.I.
02813

Westerly Police Dept.
60 Airport Road
Westerly, RI 02891
401-596-2022
401-596-7501 (Fax)

I hereby authorize the Westerly Police Department to release any personal criminal information or data from this department or from the State of Rhode Island with regard to myself. This record must be released to me or to the company listed below with whom I am seeking employment.

_____
Name of Company

TODAY'S DATE: _____

Criminal Record Check Release Form

Signature: _____
Please print below information:

Name: _____

Maiden name (s) / Alias: _____

Date of Birth: _____ S.S. # _____

Telephone # _____

Street Address: (No PO Boxes) _____

Town: _____ State _____ Zip _____

Previous Residence: _____

DO NOT WRITE BELOW THIS LINE

Official Use Only

Criminal Record Information:

Town of Westerly	**Record**	**YES**	**NO**
State of Rhode Island BCI	**Record**	**YES**	**NO**
Are records attached?		**YES**	**NO** **See below**

Explanation of Police Record below this line

_____
_____
_____
_____

_____ _____
Clerk / Officer Signature **Date**

DCFD Applicant Medical Form

RELEASE
PURSUANT TO
THE CONFIDENTIALITY HEALTH CARE INFORMATION ACT
RHODE ISLAND GENERAL LAWS 5.37, 3-4 (d)

1. I hereby consent, authorize and direct _____ to release any and/or all necessary information from the health record(s) of:

NAME		Telephone	
DOB		SSN	
Address		Patient #	

I understand that the information requested is to ensure that I meet the standards of the 13 Essential Job Tasks of a firefighter in accordance with Chapter 9 of NFPA 1582. I further understand that my immunization status will be provided.

2. This information is to be released to: Chief Christopher DeGrave, Dunn's Corners Fire Department, 1 Langworthy Rd, Westerly, RI 02891, or via email: chief@dunnscornersfire.com.

3. This authorization has no expiration date.

4. A copy of this authorization is to be treated the same as an original, and Chief Christopher DeGrave further agrees not to release or transfer any such information to any person or persons other than its agents and employees, investigators, medical or technical experts in its employ.

Signed: _____ Date: _____ _____
[Print Name]

Dear Health Care Provider;

The individual who has executed the above medical information release is applying to become a volunteer firefighter with the Dunn's Corners Fire Department. He/she could be subjected to significant physical or emotional stresses in the process of performing their duties. The Department is required to validate the firefighter's physical capacity to meet these demands. The National Fire Protection Association (NFPA) provides us guidance on physical requirements using NFPA 1582 Standard on Comprehensive Occupational Medical Program for Fire Departments 2007 Edition.

The essential job tasks, on the reverse side, are excerpted from this standard so that you may determine if they are medically capable of handling certain physical demands. Please review the following job tasks and identify his/her abilities or limitations in order to determine at what level the member can participate in firefighting activities. In addition to this form we recommend you also consider an electrocardiogram and pulmonary function testing as part of your evaluation.

Should you have any questions regarding this clearance please feel to call Chief DeGrave at 401-322-0577.

Thank you for your anticipated cooperation.

Chief Christopher DeGrave

DCFD Applicant Medical Form

The applicant's physician shall use the validated list of essential job tasks below in evaluating the ability of a member with specific medical conditions to perform specific job tasks. The physician will indicate below which tasks the applicant is medically able to perform as an applicant until the department performs its Annual NFPA 1852 Physicals.

National Fire Protection Agency's Essential Job Tasks	YES	NO
(1)*Performing fire-fighting tasks (e.g., hose line operations, extensive crawling, lifting and carrying heavy objects, ventilating roofs or walls using power or hand tools, forcible entry, etc.), rescue operations, and other emergency response actions under stressful conditions while wearing personal protective ensembles and SCBA, including working in extremely hot or cold environments for pro- longed time periods		
(2) Wearing an SCBA, which includes a demand valve– type positive-pressure face piece or HEPA filter masks, which requires the ability to tolerate increased respiratory workloads		
(3) Exposure to toxic fumes, irritants, particulates, biological (infectious) and non-biological hazards, and/or heated gases, despite the use of personal protective ensembles and SCBA		
(4) Depending on the local jurisdiction, climbing six or more flights of stairs while wearing fire protective ensemble weighing at least 50 lb (22.6 kg) or more and carrying equipment/tools weighing an additional 20 to 40 lb (9 to 18 kg)		
(5) Wearing fire protective ensemble that is encapsulating and insulated, which will result in significant fluid loss that frequently progresses to clinical dehydration and can elevate core temperature to levels exceeding 102.2°F (39°C)		
(6) Searching, finding, and rescue-dragging or carrying victims ranging from newborns up to adults weighing over 200 lb (90 kg) to safety despite hazardous conditions and low visibility		
(7) Advancing water-filled hose lines up to 2 1/2" in diameter from fire apparatus to occupancy [approx 150 ft], which can involve negotiating multiple flights of stairs, ladders, and other obstacles		
(8) Climbing ladders, operating from heights, walking or crawling in the dark along narrow and uneven surfaces, and operating in proximity to electrical power lines and/or other hazards		
(9) Unpredictable emergency requirements for prolonged periods of extreme physical exertion without benefit of warm-up, scheduled rest periods, meals, access to medication(s), or hydration		
(10) Operating fire apparatus or other vehicles in an emergency with emergency lights and sirens		
(11) Critical, time-sensitive, complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed spaces, that is further aggravated by fatigue, flashing lights, sirens, and other distractions		
(12) Ability to communicate (give and comprehend verbal orders) while wearing personal protective ensembles and SCBA under conditions of high background noise, poor visibility, and drenching from hose lines and/or fixed protection systems (sprinklers)		
(13) Functioning as an integral component of a team, where sudden incapacitation of a member can result in mission failure or in risk of injury or death to civilians or other team members		
(14) Has current Hepatitis B, Tetanus, and PPD immunizations		

**After reviewing the 13 Essential Job Tasks for firefighting, I certify that above named individual is or is not medically cleared for the tasks as indicated above.

_____ Date: _____

Signature of Health Care Provider

_____ Phone # _____

Printed Name of Health Care Provider

VFIS®
A Division of Glatfelter Insurance Group

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** Dunn's Corners Fire Department **Policy Number** _____
☐ _____ **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	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class	**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: _____ 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.

ACCIDENT AND SICKNESS PROGRAM

COVERAGE OVERVIEW

WHO IS COVERED?*

All classes of members, including:

- ☑ Volunteers, including Paid On-Call
- ☑ Part-Time Paid Members (average less than 25 hours weekly)
- ☑ Junior Members
- ☑ Members in training
- ☑ Auxiliary Members
- ☑ Commissioners, Directors and Trustees
- ☑ Deputized Bystanders (during participation in emergency)
- ☑ Non-Members asked by the organization or auxiliary to assist
- ☑ Administrative Personnel (Paid Employees who do not train for or respond to emergencies)

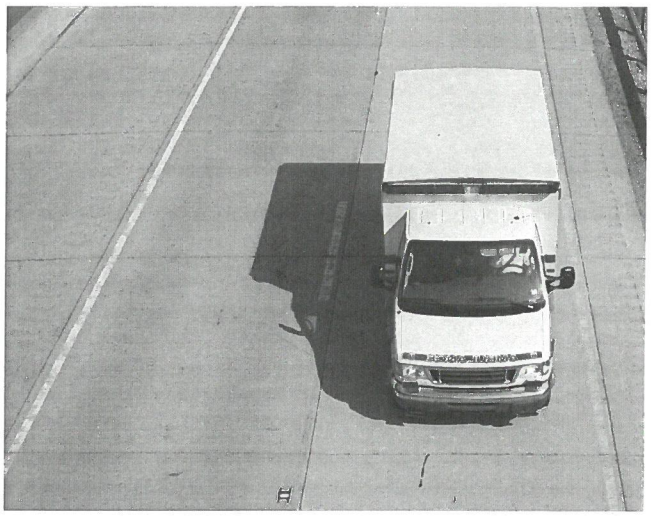
OPTIONAL: Career Members - Paid Employees (average 25 hours or more weekly)

WHEN DOES COVERAGE APPLY?*

For Injuries and Illnesses sustained while participating in normal duties such as:

- Emergency Response (Fire and EMS)
- Classroom Training and Training Exercises
- Meetings and Conventions
- Firematic Events or Contests
- Fundraising for Policyholder or Participating Organization
- Official functions intended to further the Participating Organization's business, (e.g., installation dinners)
- Travel to and from all normal duties
- Authorized Public Safety Events
- Administrative and Maintenance Duties

*May vary by state based on Department of Insurance requirements. See policy for state specific language.



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America's Leading Insurer of *Emergency Organizations*℠

DEATH BENEFITS

- Death
- Heart attack or stroke at or within 48 hours of emergency response or training
- Seat Belt
- Safety Vest
- Military*
- Dependent Child & Education (per dependent child)
- Spousal Support & Education
- Memorial (paid to department)*
- Dependent Elder (per dependent elder)
- Repatriation

OPTIONAL DEATH, DISMEMBERMENT AND PARALYSIS BENEFITS

- 24-Hour Accident – Injury Only*
- Off-Duty Accident – Injury Only*
  - Quadriplegia, Paraplegia & Hemiplegia are payable at 200%
  - Uniplegia is payable at 100%

Current Rosters must be maintained by the department for these benefits.

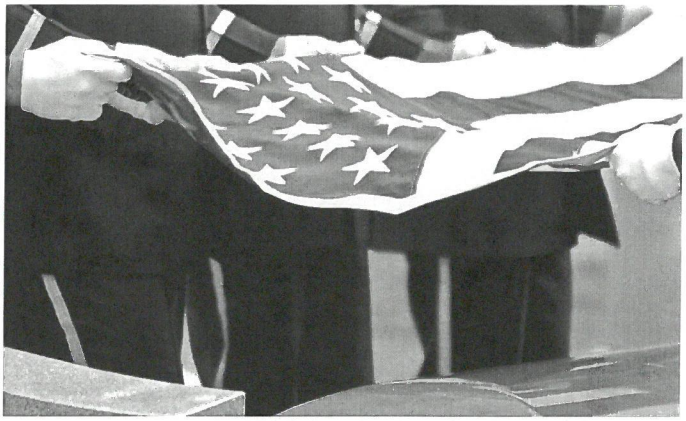
*Not available in all states

LUMP SUM LIVING BENEFITS

- Accidental Dismemberment and Paralysis
- Permanent Impairment:
  - Injury, Illness, Vision and Heart
- Cosmetic Disfigurement Resulting From Burns
- HIV Positive ‡

‡Not available to the residents of NY State

All of the lump sum benefits listed above are in addition to medical expense benefits or disability income benefits payable under the policy.



IMPORTANT FOR ALL DEATH BENEFITS: Keep current, properly completed beneficiary forms in your organization's file. Death benefits are paid to those listed on the most recent form or, if not designated, according to the policy terms. An annual review is recommended due to life changes (marriage, divorce, death, etc.). Beneficiary forms are available at vfis.com.

MEDICAL EXPENSE BENEFITS *(Medical benefits may vary by state.)*

- Medical Expenses

  Includes heart attack or stroke during a Covered Activity or directly resulting from participation in a Covered Activity and receiving medical treatment within 48 hours.
- Medical Expenses – Such as:

  a. Medical, hospital or surgical treatment;

  b. Home health care;

  c. Nursing services prescribed and monitored by a physician;

  d. Post-exposure Prophylaxis Protocol (PEP) treatment, when such treatment is advised by the attending physician;

  e. Infectious Disease screening test(s); and

  f. Post-exposure preventive inoculations as a result of participation in a Covered Activity
- Cosmetic Plastic Surgery
- Post-Traumatic Stress Disorder
- Critical Incident Stress Management
- Family Expense
- Family Bereavement and Trauma Counseling

OTHER BENEFITS

- Transition**
- Felonious Assault
- Home Alteration and Vehicle Modification

OPTIONAL BENEFITS

- Weekly Hospital Benefit
- First Week Total Disability Benefit
- Coordinated 28-Day Total Disability Benefit
- Extended Total Disability Benefit (520 weeks)**
- Long-Term Total Disability (to Age 70)**
- Weekly Injury Permanent Impairment COLA**
- Long-Term Total Disability COLA**
- Extra Expense Benefit**
- Special Events Benefit Rider – Coverage for unique events held by the organization*
- Organized Team Sports Rider - To cover sanctioned league sports*

*Availability may vary by state

**Optional for career members

WEEKLY INCOME BENEFITS
TOTAL DISABILITY

- First 28 Days - Benefit selected paid regardless of other sources of income.
- After 28 Days – Benefit equals:
  - Pre-disability wages less other income benefits paid or payable
  - Up to benefit amount selected
- Cost of Living Adjustment (COLA):
  - Benefit increases each July 1, after 52 consecutive weeks of disability
  - 5% minimum – 10% maximum increase (per CPI)
- Total Disability Benefit Periods:
  - Basic: 260 Weeks
  - Extended: 520 Weeks
  - Long Term: to age 70

PARTIAL DISABILITY

- First 28 Days – 50% of benefit selected paid regardless of other income.
- After 28 Days - Benefit equals:
  - Pre-disability wages less other income benefits paid or payable
  - Up to benefit amount selected
  - Maximum benefit period 52 weeks

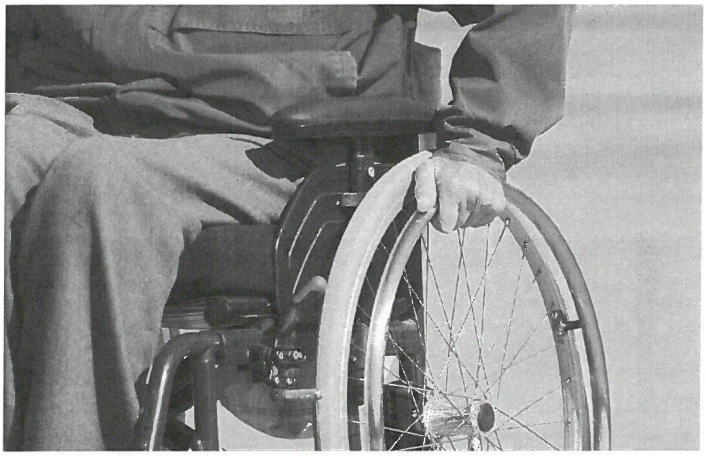
OCCUPATIONAL RETRAINING BENEFIT

- Pays for occupational retraining if the Insured becomes Permanently Totally Disabled and we agree to a rehabilitation program.

WEEKLY INJURY PERMANENT IMPAIRMENT**

- Income benefit payable for life with 50% or greater impairment rating.
  - Paid in addition to any benefit paid or payable under the policy
  - Payable even if the Member returns to work in any job

**Optional for career members



EXCLUSIONS*

Insurer will not cover any loss caused by or resulting from:

1) Suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
2) Injuries that happen while flying except:
a) As a passenger on a commercial aircraft; or
b) A passenger on any aircraft while taking part in a Covered Activity;
3) Injuries that happen while flying as a crew member, or during parachute jumps from the aircraft;
4) War or any act of war, whether declared or undeclared;
5) Mental or emotional disorders, except as specifically provided for covered Post-Traumatic Stress Disorder;
6) Treatment of alcoholism or drug addiction and any complications arising therefrom, except loss caused by Injury sustained during and resulting from a Covered Activity;
7) Illness, except as provided by the policy;
8) Military service of any state or country;
9) Any form of football, field hockey, ice hockey, lacrosse, soccer and boxing;
10) Any league sports event, except as covered under the Organized Team Sports Rider; or
11) Cancer

*Exclusions may vary by state

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Represented By: