



Greater Manassas Volunteer Rescue Squad

P.O. Box 123
Manassas, Virginia 20108-0123

www.gmvrs.org
703-361-2030

Dear Applicant,

Thank you for your interest in the Greater Manassas Volunteer Rescue Squad. In order to make a membership decision, we need a thorough and detailed review of your qualifications. Please complete the attached application as carefully and accurately as possible. Our membership guidelines are specific and the information you provide is weighed heavily in the review process.

The Greater Manassas Volunteer Rescue Squad does a thorough background investigation of all applicants prior to becoming a member. In addition to verifying all the information on your application, we will be doing a motor vehicle, criminal history, and reference checks as part of your background investigation.

Our goal is to provide opportunities to the best-qualified applicants and to maintain a high standard of professionalism throughout the Greater Manassas Volunteer Rescue Squad.

Upon completion of this application, please take a few moments to review the information for accuracy.

Sincerely

Michael Enright
President



Greater Manassas Volunteer Rescue Squad

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APPLICATION FOR MEMBERSHIP

Today's Date: _____ / _____ / _____

Full (Legal) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ / _____ / _____ SSN: _____

Phone (home): _____

Phone (work): _____

Phone (other): _____

Gender: Male Female

Race: _____

Occupation: _____

Name and Address of Employer: _____

Emergency Contact Person: _____ Emergency Contact Address: _____

Emergency Contact Phone: _____ City: _____ State: _____ Zip: _____

List three (3) non-squad, non-related references that you have chosen to complete a character reference sheet. References should be 18 years of age or older. **Please give complete addresses.**

Name: _____ Address: _____

Phone Number: _____ City: _____ State: _____ Zip: _____

Name: _____ Address: _____

Phone Number: _____ City: _____ State: _____ Zip: _____

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CERTIFICATIONS

If you currently possess any certifications that apply please list them below (CPR, EMT, EVOC, etc):

If you are currently a member, or have ever been a member with another fire or rescue department, please list the company, a contact person, and the reason for leaving that fire or rescue department (preferably the chief or president).

Department and Contact:

Address:

Reason for Leaving:

I certify that the information contained in this application is correct to the best of my knowledge and understand that deliberate falsification of this information is grounds for dismissal in accordance with the Greater Manassas Volunteer Rescue Squad by laws. I authorize the references listed to give you any pertinent information they may have, personal or otherwise and release all parties from all liability for any damage that may result from furnishing it to you.

I have read and fully understand all information stated above.

Applicant's Printed Name:

Applicant's Signature:

Date:



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APPLICANT MEDICAL STATEMENT

Name: _____ Date: _____

Physician: _____ Phone: _____

Allergies (medications and non-medications): _____

Current Medications: _____

Significant Medical History: _____

Do you have any back related illness or injuries that would limit your lifting abilities? Yes No
If yes, please explain: _____

Have you ever been treated for alcohol or drug abuse? Yes No
If yes, please explain: _____

Are you currently, or have you ever been diagnosed or treated for any of the below-listed items? (Please check all that apply.)

- | | | | | | |
|--------------------|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizure Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Syncope / Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked yes to any of the above listed items, please give a brief explanation: _____

All information contained in this form is for confidential Rescue use only.

I, _____, certify the above information is complete, accurate, and true to the best of my knowledge.

Applicant's Printed Name: _____

Applicant's Signature: _____ Date: _____



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HEALTH HISTORY AND IMMUNIZATION RECORD

A separate medical record is required for each employee and is to be kept for the length of employment plus 30 years. This information is particularly important in determining vaccination status and recommendations for treatment in the event of an exposure incident.

Please note that this information will be kept confidential and may be accessed by the employee at any time upon written request to the Infection Control Officer. Please keep the following information as accurate as possible.

<u>Disease History</u>		<u>Date</u>	<u>Disease History</u>		<u>Date</u>
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	HIV Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

Immunization Record

HBV Series

Dates Received: _____
Vaccine Type: _____ Titer Results: _____

Measles, Mumps, Rubella (MMR)	Date: _____	Booster Date: _____
Tetanus / Diphtheria	Date: _____	
Influenza Vaccine	Date: _____	
TB Skin Testing	Date: _____	
Polio	Date: _____	
Varicella (Chickenpox)	Date: _____	

I attest that the above information is complete and accurate to the best of my knowledge. I understand that this information will only be used as a baseline in the determination of treatment for a possible exposure incident and as a record of my immunization status.

Applicant's Printed Name: _____

Applicant's Signature: _____ Date: _____



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PRELIMINARY INTERVIEW SHEET

- Applicant must provide a copy of their Virginia Drivers License & DMV record.
- Applicant must provide copy of their High School Diploma or GED [within 30 days before being voted on as a trial member].
- CPR for Healthcare Providers Certification prior to becoming a trial member.
- Trial membership period of six (6) months after a minimum of 30 days preliminary status.
- Duty crew assignments:
 - 1 night crew assigned
 - 1 weekend (36 hours) crew assigned
 - Holiday assignment
- Certifications required for senior membership (EMT, EVOC)
- Business Meeting (4th Wednesday of each month)
- Squad In-House Training (1st Wednesday of each month)
- Building Tour
- Indoctrination Program Packet
- Membership Committee – any questions contact
Mike Orazi, Randy Cusick, Nancy Orndoff
- Chief: Dave Burns
Assistant Chief: Curt Huntington
Captain: Randy Cusick
Lieutenants: Maile Jones, Mike Davidson, Robin Kerhart
- President: Mike Enright
Vice President: Nancy Orndoff
Secretary: Liz Heinbuch
Treasurer: Stephanie Popish
- Introduction to Career Staff

Applicant's Printed Name:

Applicant's Signature:

Date:

Membership Committee's Printed Name:

Membership Committee Signature:

Date: