CAL FIRE / SLO COUNTY FIRE DEPARTMENT

PAID CALL FIREFIGHTER APPLICATION

PLEASE PRINT

COMPANY NAME/NUMBER:______

NAME:____ BIRTHDATE:________________
First Middle Last

MAILING ADDRESS:____
Street City State Zip

RESIDENTIAL ADDRESS:____
Street City State Zip

HOME PHONE:____________________ SOCIAL SECURITY:____________________

DRIVER'S LICENSE #:____________________ ATTACH CERTIFICATE OF VEHICLE LIABILITY INSURANCE

OCCUPATION: ____________________ EMPLOYER'S NAME: ____________________

WORK PHONE #: ____________________ YEARS WORKED: __________

EMERGENCY NOTIFICATION: ____
Name Phone Relationship

DUE TO THE PUBLIC TRUST PLACED IN FIREFIGHTERS, AND OTHER AGENCY REQUIREMENTS REGARDING CRIMINAL HISTORY, A CRIMINAL HISTORY BACKGROUND CHECK WILL BE COMPLETED. THE RECORD SEARCH INCLUDES DEPARTMENT OF JUSTICE AND DEPARTMENT OF MOTOR VEHICLE RECORDS. APPLICANTS WITH CONVICTIONS OR ARRESTS IN THE FOLLOWING FELONY CATEGORIES WILL BE DENIED MEMBERSHIP: CRIMES AGAINST PERSONS, (E.G., ASSAULT, BATTERY, HOMICIDE, SEX CRIMES); CRIMES AGAINST PROPERTY, (E.G., ARSON, THEFT, AND BURGLARY).

ARE YOU WILLING TO SUBMIT TO A MEDICAL EXAMINATION: ________

LIST TWO REFERENCES IN ADDITION TO EMPLOYER: ______________________________
(include address, phone number) ______________________________
____

I CERTIFY ALL THE ABOVE INFORMATION TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISSTATEMENTS OF MATERIAL FACTS WILL SUBJECT ME TO DISQUALIFICATION OR DISMISSAL.

APPLICANT SIGNATURE: ______________________________ DATE: __________

CAL FIRE / SLO COUNTY FIRE DEPARTMENT

AUTHORIZATION TO RELEASE INFORMATION

As an applicant for paid call firefighter appointment with the San Luis Obispo County Fire Department, I am required to furnish information for use in determining my moral, physical, and mental qualifications. In this connection, I authorize release of any and all information that you may have concerning me, including information that you may have concerning me, including information of a confidential or privileged nature.

I hereby release you, your organization, or others from any liability or damage which may result from furnishing the information requested.

A photocopy of this authorization shall be as valid as the original.

Name: ______________________________

Signature: ___________________________

Date: _______________________________

NOTE: YOU MAY RETAIN THIS FORM FOR YOUR FILES.

CAL FIRE / SLO COUNTY FIRE DEPARTMENT

635 N. SANTA ROSA • SAN LUIS OBISPO • CALIFORNIA 93405 • (805) 543-4244

PAID CALL FIREFIGHTER (PCF) PHYSICAL/MENTAL REQUIREMENTS

Duties for the position of PCF involve field work requiring physical performance call for above average ability, endurance, and superior condition, including occasional demand for extraordinary strenuous activities in emergencies, under adverse environmental conditions, and over extended periods of time.

A PCF must have visual acuity (Snellen) of not less than 20/100 without correction each eye corrected to not less than 20/30 in one eye; hearing adequacy within spee frequencies (uncorrected); full use of both hands and feet; must have the necessary strength and agility required for extensive bending, stooping, and squatting; must b able to lift or carry heavy sudden jerking movements of his/her back and limbs wh for instance, he/she is being endangered by falling rocks and trees; must be able to work in conditions where there is intense heat; may be exposed to heavy smoke an dust.

A PCF responds to fires, rescues, and other emergencies as the driver or crew mem on fire engines, rescue units, and other vehicles; uses equipment and tools perform such procedures as: raise, climb, and lower ladders; extend and advance hose line into burning buildings; cut holes in buildings with axe or other tools; fight wildland fires, using shovel, axe, McLeod, Pulaski, back pump, and other tools; and perform other fire fighting duties and operates other tools as is necessary.

ARDUOUS PHYSICAL WORK:

Duties involve field work requiring physical performance calling for above-average ability, endurance, and superior condition, including occasional demand for extraordinarily strenuous activities in emergencies, under adverse environmental conditions and over extended periods of time; requires running, walking, difficult climbing, jumping, twisting, bending, and lifting over 25 pounds; pace of work is typically set by the emergency situation.

San Luis Obispo County Fire Department
RESPIRATORY PROTECTION PLAN
EMPLOYEE MEDICAL QUESTIONNAIRE

Date: ______________________ Battalion: ______________________

Employee's Name: ______________________ Station Address: ______________________

Address: ______________________ : ______________________

Phone Number: ______________________ Phone Number: ______________________

Date of Birth: ____________ Age: ______ Job Classification: ______________________
SSN: ______________________
Number of years employed as a PCF: (Please check one) 1 to 5 ☐ 6 to15 ☐ 16 to 25 ☐ 26 to 30+ ☐

To the employee: Can you read (check one): Yes ☐ No ☐
The medical questionnaire was developed by the San Luis Obispo County Fire Department as part of the comprehensive medical evaluation process to determine fitness to use respiratory protection equipment. <u>It is important that this confidential medical questionnaire not to be shared with co-workers, supervisors, or others not involved in the medical review process. If you have any questions or concerns regarding the required medical review process, please contact the</u> Community Health Center (CHC) 269-1519 **Failure to answer each question will cause the questionnaire to be returned to you.**

Your supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must tell you how to deliver or send this questionnaire to the health care professional who will review it. <u>Neither your supervisor nor management may look at or review your answers.</u>

Part A
Section 1. The following information must be provided by every employee who is required to use any type of respirator (please print).

1. Sex (circle one): Male/Female
2. Your height __________ Ft. ______ In.
3. Your weight: ____ lbs.
4. Your job title: ______________________
5. Phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ______________________
6. The best time to phone you at this number: ______________
7. Has your supervisor told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐
8. Check the type of respirator you will use (you can check more than one category):
   a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. _____ Half or full-facepiece type
   c. _____ Powered-air purifying, supplied-air.
   c. _____ Self-contained breathing apparatus.
9. Have you worn a respirator (check one): Yes ☐ No ☐
   If "yes" what type(s):
   a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. _____ Half or full-facepiece type.
   c. _____ Powered-air purifying, supplied-air.
   c. _____ Self-contained breathing apparatus.

Section 2. (please check applicable "yes" or "no" box).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No ☐
2. Have you ever had any of the following conditions?
   a. Seizures (fits). Yes ☐ No ☐
   b. Diabetes (sugar disease). Yes ☐ No ☐
   c. Allergic reactions that interfere with your breathing. Yes ☐ No ☐
   d. Claustrophobia (fear of closed-in places). Yes ☐ No ☐
   e. Trouble smelling odors. Yes ☐ No ☐
3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis. Yes ☐ No ☐
   b. Asthma. Yes ☐ No ☐
   c. Chronic bronchitis Yes ☐ No

d. Emphysema. Yes ☐ No ☐
e. Pneumonia. Yes ☐ No ☐
f. Tuberculosis. Yes ☐ No ☐
g. Silicosis. Yes ☐ No ☐
h. Pneumothorax (collapsed lung). Yes ☐ No ☐
i. Lung cancer. Yes ☐ No ☐
j. Broken ribs. Yes ☐ No ☐
k. Any chest injuries or surgeries. Yes ☐ No ☐
l. Any other lung problem that you have been told about. Yes ☐ No ☐

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
a. Shortness of breath. Yes ☐ No ☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline. Yes ☐ No ☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground. Yes ☐ No ☐
d. Have to stop for breath when walking at your own pace on level ground. Yes ☐ No ☐
e. Shortness of breath when washing or dressing yourself. Yes ☐ No ☐
f. Shortness of breath that interferes with your job. Yes ☐ No ☐
g. Coughing that produces phlegm (thick sputum). Yes ☐ No ☐
h. Coughing that wakes you early in the morning. Yes ☐ No ☐
i. Coughing that occurs mostly when you are lying down. Yes ☐ No ☐
j. Coughing up blood in the last month. Yes ☐ No ☐
k. Wheezing. Yes ☐ No ☐
l. Wheezing that interferes with your job. Yes ☐ No ☐
m. Chest pain when you breathe deeply. Yes ☐ No ☐
n. Any other symptoms that you think may be related to lung problems. Yes ☐ No ☐

5. Have you ever had any of the following cardiovascular or heart problems?
a. Heart attack. Yes ☐ No ☐
b. Stroke. Yes ☐ No ☐
c. Angina. Yes ☐ No ☐
d. Heart failure. Yes ☐ No ☐
e. Swelling in your legs or feet (not caused by walking). Yes ☐ No ☐
f. Heart arrhythmia (heart beating irregularly). Yes ☐ No ☐
g. High blood pressure. Yes ☐ No ☐
h. Any other heart problem that you've been told about. Yes ☐ No ☐

6. Have you ever had any of the following cardiovascular or heart symptoms?
a. Frequent pain or tightness in your chest. Yes ☐ No ☐
b. Pain or tightness in your chest during physical activity. Yes ☐ No ☐
c. Pain or tightness in your chest that interferes with your job. Yes ☐ No ☐
d. In the past two years, have you noticed your heart skipping or missing a beat. Yes ☐ No ☐
e. Heartburn or indigestion that is not related to eating. Yes ☐ No ☐
f. Any other symptoms that you think may be related to heart or circulation problems. Yes ☐ No ☐

7. Do you currently take medication for any of the following problems?
a. Breathing or lung problems. Yes ☐ No ☐
b. Heart trouble. Yes ☐ No ☐
c. Blood pressure. Yes ☐ No ☐
d. Seizures (fits). Yes ☐ No ☐

8. If you have used a respirator, have you ever had any of the following problems? Yes ☐ No ☐
If no, go to question 9.
If you have used a respirator, check all that apply.
a. Eye irritation. Yes ☐ No ☐
b. Skin allergies or rashes. Yes ☐ No ☐
c. Anxiety. Yes ☐ No ☐
d. General weakness or fatigue. Yes ☐ No ☐
e. Any other problem that interferes with your use of a respirator. Yes ☐ No ☐

9. Would you like to talk to the health care professional about your answers to this questionnaire? Yes ☐ No ☐

10. Have you ever lost vision in either eye (temporarily or permanently)? Yes ☐ No ☐

11. Do you currently have any of the following vision problems?
a. Wear contact lenses. Yes ☐ No ☐
b. Wear glasses. Yes ☐ No ☐
c. Color blind. Yes ☐ No ☐
d. Any other eye or vision problem. Yes ☐ No ☐

12. Have you ever had an injury to your ears, including a broken eardrum? Yes ☐ No ☐

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing. Yes ☐ No ☐
   b. Wear a hearing aid. Yes ☐ No ☐
   c. Any other hearing or ear problem. Yes ☐ No ☐

14. Have you ever had a back injury? Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet. Yes ☐ No ☐
   b. Back pain. Yes ☐ No ☐
   c. Difficulty fully moving your arms and legs. Yes ☐ No ☐
   d. Pain or stiffness when you lean forward or backward at the waist. Yes ☐ No ☐
   e. Difficulty fully moving your head up or down. Yes ☐ No ☐
   f. Difficulty fully moving your head side to side. Yes ☐ No ☐
   g. Difficulty bending at your knees. Yes ☐ No ☐
   h. Difficulty squatting to the ground. Yes ☐ No ☐
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes ☐ No ☐
   j. Any other muscle or skeletal problem that interferes with using a respirator. Yes ☐ No ☐

Part B

1. List medications you use on a regular basis while wearing protective equipment (include over-the-counter medications):

____

____

2. Have you ever had or been advised to have an exercise treadmill test? Yes ☐ No ☐

   If **yes**, when was the last treadmill done? ____________________

   Were you advised to restrict your activities based on the results? Yes ☐ No ☐

3. List **previous** occupations or activities which you believe may have exposed you to airborne toxic substances (include items such as pertinent military service, pesticide application, mining activities, rock drilling, asbestos abatement, lead abatement, etc.):

Previous Occupation/Activities	Exposure

4. List any **present** occupations, other than CDF or activities that you feel may expose you to airborne toxic substances (mining, smelting metals, welding, etc.):

Present Occupation/Activities	Exposure

5. Are you on a HAZMAT Team? Yes ☐ No ☐

   5a. When was your last medical clearance examination for HAZMAT work?

   Date: ____________________

Final Question

Is there anything about your work or health that should be considered in determining your ability to perform your work activities while wearing protective equipment that was not asked above? If yes, please advise below:

CERTIFICATION: I certify that I have provided true and complete information concerning my health.

______________________________ ______________________________

EMPLOYEE SIGNATURE DATE

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership

☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ __

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United Sates,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,