

Wallkill Hook, Ladder and Hose Co., Inc.

P.O. Box 460
Wallkill, NY 12589
(845)895-9708
(845)895-3729 Fax

Application for Membership

Date: _____

Name: _____

Address: _____

Telephone: Home: _____ Work: _____

How long have you resided at this address: Years: _____ Months: _____

How long have you resided in New York State: Years: _____ Months: _____

Are you 18 years of age or older? Yes: _____ No: _____ Date of Birth: _____

Are you currently employed? Yes: _____ No: _____ Hours work: _____

If "Yes" give employer information below. May we contact your employer as a reference? Yes: _____ No: _____

Name of Company: _____

Address: _____

Telephone No: _____

Do you have a valid New York State Driver's License? If "Yes" please provide number.

Please indicate your availability to participate in normally required fire department activities (meetings, drills, and emergency calls). Please check appropriate time periods:

Weekdays: Days _____ Evenings _____ Nights _____

Weekends: Days _____ Evenings _____ Nights _____

Previous emergency service experience (include only fire, rescue, police, and emergency medical service agencies):

Name of Agency: _____

Address: _____

Contact Person: _____

Telephone: _____

Wallkill Hook, Ladder and Hose Co., Inc.

P.O. Box 460
Wallkill, NY 12589
(845)895-9708
(845)895-3729 Fax

Application for Membership (cont.)

Have you ever been a member of the United States Armed Forces? Yes ___ No ___
If the Answer is "Yes" did you receive a dishonorable discharge? Yes ___ No ___

Have you ever been convicted of plead guilty to a felony, misdemeanor, insurance fraud,
arson, or a reduction of one of these offenses? Yes: ___ No: ___
If "Yes" give details on the attached sheet.

OSHA regulations require that you pass a physical examination before becoming an
interior structural firefighter. The department's designated physicians will provide you
with a free medical examination. Will you be willing to undergo a medical examination?
Yes ___ No ___

ADDITIONAL INFORMATION

Emergency Contact: _____

Current Physician: _____

Blood Type if known: _____

Social Security Number: _____

Racial Appearance: White ___ Black ___ Am. Indian ___ Japan ___ Chin. ___ Other ___

Skin Tone: Light ___ Medium ___ Dark ___

Height: ___ Ft. ___ In.

Place of Birth: _____

Applicant's Signature: _____

Date: _____

OFFICIAL USE ONLY

President: _____ Date: _____

Chief: _____ Date: _____

VOTE: _____ Date: _____