



City of Inverness Volunteer Fire Department Membership Application

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Administration Office
212 W. Main Street
Inverness, FL 34450
(352) 726 2611

PLEASE PRINT

We consider applicants for all positions, without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

Date: _____ Applying for: Volunteer Firefighter/EMS [] Associate/Support/Auxiliary []

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ email address (optional): _____

Drivers License Number: _____ State: _____ Sex: M / F

Employer/Occupation: _____

Have you ever been convicted of a felony or misdemeanor? Yes / No . If yes, explain: _____

Do you have any Firefighting/EMS experience or training? Yes / No . If yes, explain: _____

List Three Unrelated References:

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

I understand when submitted, the application and contents are a public document and subject to review by the public and media upon request, after appropriate redaction has been completed by city representative.

The City of Inverness Volunteer Fire/Rescue Department is an equal opportunity volunteer agency that welcomes all applicants after a driver and criminal background check. Upon becoming a member of the Department, it is your responsibility to become completely familiar with and understand the Standard Operating Guidelines (SOGs) for the Department. Further, you will be held accountable for any actions found inappropriate to or in direct violation of the Standard Operating Guidelines for the Department.

Signature: _____ Date: _____



City of Inverness Volunteer Fire Department Medical Information



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Last Name _____ First Name _____ Middle Name _____

The information on this page is confidential and will be kept in a file separate from your Membership Application. The medical information is exclusively accessible by the Fire Chief or designated staff for the purpose of providing proper medical treatment/transport in the event you become incapacitated.

Emergency Contact:

Contact Name _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip _____

Do you have any allergies: Yes / No. If yes, please explain: _____

Do you have any pertinent medical history: Yes / No. If yes, please explain: _____

Do you take any medications: Yes / No. If yes, please explain: _____

Do you have any disabilities: Yes / No. If yes, please explain: _____

Who is your primary care physician: _____ Phone number: _____

What is the date of your last physical: _____ What is your blood type: _____

Which hospital do you prefer: _____

Do you have medical insurance: Yes / No. If yes, list the provider and policy number: _____

You are covered by Florida Workers' Compensation while participating in any City of Inverness Volunteer Fire Department sponsored event and it is extremely important you immediately report any injury sustained to the supervising Firefighter/EMT during an event.

If changes occur to any of the medical information above, a new form should be completed indicating the change.

Signature: _____ Date: _____



City of Inverness Volunteer Fire Department Applicant Waiver Form

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Applicant Waiver Form: *(To be signed by all job applicants along with application form.)*

I agree and understand that all the information and statements on my application are correct and no attempt has been made to conceal or withhold pertinent information. I agree that any omission, falsification or misrepresentation is cause for my immediate termination at any time during my employment.

In connection with this request, I authorize all corporation, companies, credit agencies, government agencies, person, education institutions, law enforcement agencies and former employers to release information they may have about me, and release them from any liability and responsibility from doing so; further, I authorize the procurement of an investigative consumer report and understand that such report may contain information as to my background, mode of living, character, personal reputation and driving records.

This authorization, in original and copy form, shall be valid for this and any future reports that may be requested.

I hereby authorize investigation of all statements at this time with no liability arising there from.

Name (please print): _____

Date of Birth: _____ Social Security Number: _____

Signature: _____ Date: _____

City Representative: _____ Date: _____