Holbrook Volunteer Fire Department

390 Terry Boulevard, Holbrook, NY 11741

Phone: (631) 588-0099 Fax: (631) 588-0136

Emergency (631) 588-1118

Application for Membership Packet

(Revised 07-24-23)

This packet contains the following items.

Page 1 - Information for applicants.
Page 2, 3 & 4 - Application form
Page 5 - Firefighter (Division 1) agility test
Page 6 - EMS (Division 2) agility Test
Page 7 - Authorization for release of information form
Page 8 - NYS DOCJ Background check form
Page 9 - HIPAA Authorization form instructions
Page 10 - NYS student ID form
Page 11 - HIPAA Authorization form

Please ensure this packet contains all the above items.

Applicants are required to:

1. Read the information for applicants' sheet
2. Complete the application form in blue or black ink (please print)
3. Read and sign the release form on page 7
4. Fill out the background check form on page 8
5. Fill out the HIPAA form on page 9
6. Submit a copy of your driver license
7. Submit a copy of your High School diploma or GED certificate
8. Submit a copy of your EMT card
9. Submit a copy of all Firefighting certificates
10. Read the agility test forms, discuss with your doctor, and sign the form.

Applications must be fully completed with all requested information, documentation and signatures as requested. Incomplete applications will delay the review and processing of your application. The application committee will review your application and will contact you to schedule an in-person interview and agility test.

Thank you for your interest in joining the Holbrook Fire Department.

INFORMATION FOR APPLICANTS

TO BE CONSIDERED FOR MEMBERSHIP YOU MUST BE 18 YEARS OF AGE, A HIGH SCHOOL GRADUATE OR POSESS A G.E.D. AND RESIDE IN THE HOLBROOK FIRE DISTRICT (Which is south of the LIRR tracks, West of Waverly Avenue, East of the L.I. MacArthur Airport, North of Church St South bordering Bayport, unless authorized by Municipal Law.).

Upon joining the department, each new member, with the exception of those transferring from another department, serves a probationary period of up to 24 months. During this time, you will be expected attend a number of classes and training sessions designed to teach you the job of being a firefighter (Division 1) or an Emergency Medical Technician (Division 2). In addition, all members are expected to attend monthly scheduled activities which include Department Meetings, Company Meetings, Department drills, work calls and unscheduled fire and ambulance calls. In addition, all members of division 2 must enroll in a New York State Emergency Medical technician course if not already certified.

Your membership is voluntary. That is, you have the right to remain or resign as a member of the department. All emergency calls must be considered mandatory. Therefore, no member has the right to decide which calls they will respond to. Orders of any Officer must be obeyed. With regards to drills, work calls and meetings, it is the member's duty to attend as many as possible. You will be required to maintain a certain yearly attendance percentage.

Of course, Fire and Rescue emergencies are not structured throughout the day. As a result, the amount of time required is more demanding than other organizations. Some calls can be over in a few minutes while others can last several hours. We therefore ask that each applicant discuss the department with their family. By doing this we hope to maintain family bliss and the members of your family can be aware and supportive of the responsibilities of the work being done and what it involves.

What if I am injured? Each member is financially and medically protected by the New York State Volunteer Firefighters Benefit Law (VFBL) in case of an accident or illness ***sustained while participating in a FIREMATIC activity***. In addition, the Holbrook Fire District carries supplemental insurance and both the District and FVBL provide monetary death benefits.

Needless to say, you should be medically able to perform the tasks that will be required of you. Therefore, if your application is approved you will be requested to undergo a complete physical examination and pass an agility test (copy attached).

We trust that you fully understand and appreciate the commitment that we are asking you to make. In turn, you will become a member of one of the finest fire departments in Suffolk County with a long history of tradition and pride in helping our fellow neighbors.

Date of Application: ______/_______/______

Check one: Firefighter Division 1 ☐ Ambulance Division 2 ☐ Transfer ☐

Full Name: ____ Date of Birth: ______/_______/______

Present Address: ____

Previous Address (Last 5 years): ____

Home Phone: (________)_________-_____________ Cell Phone: (________)_________-______________

If applicant is under 18, Parental or Guardian consent is required for membership

Name of Parent/Guardian: ____

Address: ____ Phone: (________)_________-______________

Parent/Guardian Signature: _____________________________________ Date: ______/_______/________

Do you have a NYS Driver License? Yes _______ No _______

Driver License Number: ____________________ Class: ______ Expiration Date: ______/_______/________

Personal Physician: ________________________________ Phone: (________)_________-______________

Occupation: ____

Employer: ____

Address: ____ Phone: (_______)________-_______________

Emergency Contact: ____________________________________ Relation: _________________________

Address: ____

Phone: (________)_________-_____________ Cell: (________)_________-_____________

Work Phone: (________)_________-______________

Do you have previous firefighting or EMS experience? Yes _______ No _______

Department and Years of service: ____

Are you or have you been a NYS EMT? Yes _______ No _______

If yes: Certificate Number: _____________________________ Expiration Date: ______/_______/________

Have you ever been declined membership in a Fire or EMS Agency? If yes, explain: ____________________

____

Summarize your previous experience. Please list Department(s), Dates of service, Offices held, training credentials, etc. (use additional pages if necessary and attach copies of all relevant training certificates):

____
____
____
____
____
____
____
____
____
____

Please provide 2 personal references **NOT** members of the Holbrook Fire Department.

Name: ____ Phone: (________)_________-_______________

Address: ____

Name: ____ Phone: (________)_________-_______________

Address: ____

SIGNATURE

Applicant Name (Please Print): ____

I have read and understand this application. I also understand fully that if any statements given or questions answered falsely, knowingly or not, I am subject to immediate dismissal from the Holbrook Fire Department at any time and can possibly face legal charges.

Applicant Signature: ____ Date: ______/_______/________

APPLICATION COMMITTEE

Application Reviewed: ___________ Date: ______/_______/________

Applicant Interviewed: ___________ Date: ______/_______/________

Application *APPROVED* / *DENIED* (circle one) Reason: ____

After Interview, applicant *IS* / *IS NOT* (circle one) recommended for membership.

Committee Member Signature: ______________________________________ Date: ______/_______/________

DEPARTMENT SECRETARY

Application with application fee was received and read at the regular meeting of the Holbrook Fire Department held on _____/_____/_____ and the application was accepted / denied (circle one) pending ________________

____

Department Secretary Signature: _____________________________________ Date: ______/_______/________

CHIEF'S OFFICE

Physical agility test results: ____

Medical exam results: ____

NYS DOCJ Background check results: ____

Chief Signature: ____ Date: ______/_______/________

FIRE DISTRICT ENDORSEMENT

The above-named candidate has been found to be acceptable / unacceptable (circle one) for membership in the Holbrook Fire Department by the Board of Fire Commissioners.

Commissioner Signature: ____ Date: ______/_______/________

FIREFIGHTER AGILITY TEST

Name: ____ Date: ______/_______/________

An applicant failing to achieve an average score of at least 80% will not be permitted to proceed to the next phase of the application procedure.

1. Complete equipment carry/stair climb as demonstrated

Complete all 4 cycles	100 Points
Complete 3 cycles	75 Points
Complete 2 cycles	50 Points
Complete 1 cycle	25 Points
Failure to complete 1 cycle	0 Points
	Score: __________

2. Advance a 2 ½" hose line 50 feet

Complete entire exercise	100 Points
Complete first half of the exercise	50 Points
Failure to complete half the exercise	0 Points
	Score: __________

3. From a standing start, pull a charged 2 ¾" hose line 50 feet.

Complete entire exercise	100 Points
Complete first half of the exercise	50 Points
Failure to complete half the exercise	0 Points
	Score: __________

4. Raise a ground ladder from the ground to a vertical point and lower it back to the ground. Repeat 4 times.

Complete entire exercise	100 Points
Raise the ladder 3 times	75 Points
Raise the ladder 2 times	50 Points
Raise the ladder 1 time	25 Points
Failure to complete ladder raise	0 Points
	Score: __________

I have read and understand the above agility test in its entirety. I have discussed this with my family physician and he has found me to be in good health and I do not have any medical condition or debilitating disease that would be detrimental to my taking this test.

Applicant Signature: ____ Date: ______/_______/________

FIREMEDIC AGILITY TEST

Name: ____ Date: ______/_______/________

An applicant failing to achieve an average score of at least 80% will not be permitted to proceed to the next phase of the application procedure.

1. Lift and carry an Oxygen bag and ALS jump bag typically used by the Holbrook Fire Department for a distance of 50 feet in 30 seconds or less.

Completed the distance in 30 seconds or less	100 Points
Completed the distance in 30 - 40 seconds	75 Points
Completed the distance in 40 - 50 seconds	50 Points
Completed the distance in 50 - 60 seconds	25 Points
Failure to complete the exercise in 60 seconds	0 Points
	Score: __________

2. Drag a 120 lbs. unconscious patient a distance of 30 feet along an outlined path.

Completed the distance in 30 seconds or less	100 Points
Completed the distance in 30 - 40 seconds	75 Points
Completed the distance in 40 - 50 seconds	50 Points
Completed the distance in 50 - 60 seconds	25 Points
Failure to complete the exercise in 60 seconds	0 Points
	Score: __________

3. Manually perform cardiac compressions on an adult CPR mannequin at a rate of 80 compressions per minute for 3 minutes using the correct depth of 1 ½ inches.

Complete entire exercise with at least 216 compressions	100 Points
Complete 198 compressions in 2 minutes 45 seconds	75 Points
Complete 180 compressions in 2 minutes 30 seconds	50 Points
Complete 162 compressions in 2 minutes 15 seconds	25 Points
Failure to complete the exercise in 2 minutes 15 seconds	0 Points
	Score: __________

4. Assist a member in loading a patient onto a stretcher and into the ambulance. After patient has been loaded, unload the patient from the ambulance.

Exercise successfully completed	100 Points
Failure to complete exercise	0 Points
	Score: __________

I have read and understand the above agility test in its entirety. I have discussed this with my family physician and he has found me to be in good health and I do not have any medical condition or debilitating disease that would be detrimental to my taking this test.

Applicant Signature: ____ Date: ______/_______/________

APPLICANT AUTHORIZATION AND CONSENT FOR HE HOLBROOK FIRE DEPARTMENT TO CONDUCT THE REQUISITE SEARCHES IN SUPPORT OF THE APPLICATION FOR MEMBERSHIP IN THE HOLBROOK FIRE DEPARTMENT

The undersigned herby authorizes and consents to the Holbrook Fire Department and the Chief of Department conducting all necessary searches required by law in connection with my application for membership in the Holbrook Fire Department including but not limited to all searches on a Federal, State and Local level in regard to any history of conviction for Arson and any history of conviction for Sexual Offences which would require registration in the New York State Sex Offender Registry. I give this authorization and consent having been advised that the searches are a statutorily required part of the application process and having been so advised I wish to proceed with my application and give my consent and authorization for the stated purposes:

______________________________	______________________________
Name of Applicant	Signature of Applicant
______________________________	______________________________
Chief of Department	Signature of Chief of Department
______________________________	______________________________
Witness Name	Signature of Witness
________/________/________	
Date	

NEW YORK STATE DIVISION OF CRIMINAL JUSTICE SERVICES
Office of Criminal Justice Operations
Volunteer Firefighter Inquiry Form

INSTRUCTIONS: This form is to be used only by a Sheriff's Office (or OFPC, where applicable) when performing searches authorized under NY Executive Law §837-o in connection with individuals seeking membership in a Volunteer Fire Department.

This form must be U.S. mailed, faxed or hand delivered between agencies. E-mail transmission is not permissible.

Shaded boxes are required data elements.

A. DATE:

B. REQUESTING VOLUNTEER FIRE DEPARTMENT

DEPARTMENT NAME:

FIRE CHIEF NAME: SIGNATURE:

ADDRESS:

TELEPHONE NUMBER: FAX NUMBER:

1. NAME (LAST, FIRST, MIDDLE)		2. ADDRESS (Street, City, Zip Code)	
3. ALIAS AND/OR MAIDEN NAME		4. SEX M ☐ F ☐	5. RACIAL APPEARANCE White ☐ Black ☐ Indian ☐ Asian ☐ Unknown ☐ Other ☐
6. ETHNICITY Hispanic ☐ Not Hispanic ☐ Unknown ☐	7. HEIGHT Ft. In.	8. DATE OF BIRTH Month Day Year	9. PLACE OF BIRTH
10. SOCIAL SECURITY NO.			

RESULTS OF INQUIRY

INVESTIGATING OFFICER: ______________________ DATE ______________
(PRINT NAME/TITLE)

INVESTIGATING OFFICER SIGNATURE ______________________

☐ NO RECORD OF AN ARSON CONVICTION OR A CONVICTION REQUIRING REGISTRATION AS A SEX OFFENDER

☐ CONVICTED OF ARSON; NO RECORD OF A CONVICTION REQUIRING REGISTRATION AS A SEX OFFENDER

☐ CONVICTED OF A CRIME REQUIRING REGISTRATION AS A SEX OFFENDER; NO RECORD OF AN ARSON CONVICTION

☐ CONVICTED OF ARSON AND CONVICTED OF A CRIME REQUIRING REGISTRATION AS A SEX OFFENDER

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Homeland Security and Emergency Services | Fire Prevention and Control

EOSB - 601 (6/18)

Student Data Sheet

☒ Requesting New Student ID ☐ Update to Current Student ID

Student Identification #								
N	Y							

Student Name

Last Name	Suffix	First Name	M.I.

Primary Agency

FD Identification #					Appt. Date				Primary Name
5	2	5	0	1					HOLBROOK FIRE DEPARTMENT

Secondary Agency

FD Identification #					Appt. Date				Secondary Name

Student Information

Address	390 TERRY BLVD.
Address	
City	HOLBROOK State N.Y. Zip 11741

Primary Phone	- -	Primary Email	

Date of Birth					

Last 4 of Social Securiy #			

Gender *(optional)* ☐ Male ☐ Female

Education Level *(optional)*

☐ High School / GED ☐ Associates ☐ Masters
☐ Some College ☐ Bachelors ☐ Other

Submit Form

or print and email a scanned copy to:
ofpc.training@dhses.ny.gov

OFFICIAL USE ONLY

Data sheet processed by: ______________________________

Date ID emailed to student:					

Revised 01/01/2022

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ________________ to (insert date) ________________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ______________________________
  ____

Include: (*Indicate by Initialing*)

_______ **Alcohol/Drug Treatment**
_______ **Mental Health Information**
_______ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here __________ I authorize ____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ Date: ________________________
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**