



# Rolla Rural Fire Protection District

1575 East Lions Club Dr.  
Rolla, Missouri 65401  
(573) 341-2211

## *Application for Volunteer Firefighter*

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Name

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Application Date



Submit this application only to the Chief or  
an Advancement Committee member  
at any regular training meeting, held on Tuesdays at 7pm  
**DO NOT TURN THIS APPLICATION OVER TO ANYONE ELSE!**



## Education

Do You Have a High School Diploma or GED: \_\_\_\_\_

If no, list the Highest/Current Grade Level Reached in School: \_\_\_\_\_

If no and currently attending classes, list the expected graduation date: \_\_\_\_\_

List Schools and any College attended:

<b>HIGH SCHOOL</b>	NAME LOCATION	GRADUATION YEAR	SUBJECTS OR MAJOR
<b>COLLEGE</b>	NAME LOCATION	YEAR(S) ATTENDED	SUBJECTS OR MAJOR
<b>VOCATIONAL</b>	NAME LOCATION	YEAR(S) ATTENDED	SUBJECTS OR MAJOR
<b>OTHER</b>	NAME LOCATION	YEAR(S) ATTENDED	SUBJECTS OR MAJOR

## Background

How Long Have You Lived in Rolla? \_\_\_\_\_

Your Personal Vehicle: \_\_\_\_\_  
YEAR                      MAKE                      MODEL                      LICENSE & STATE

Insurance Company: \_\_\_\_\_  
NAME  
 \_\_\_\_\_  
ADDRESS    CITY                      STATE                      ZIP

Traffic Violations Within the Past Three Years:

DATE	DESCRIPTION OF OFFENSE	LOCATION

Has Your Drivers License ever been Denied, Suspended, Revoked or Restricted in any way?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Have You Ever Been Arrested?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Have you ever spent time in jail?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Have You Ever Used any Illegal Drugs?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Have You Ever Taken Treatment for Alcohol or Narcotics Abuse?	<input type="checkbox"/> NO	<input type="checkbox"/> YES

- If you answered "YES" to any of the above questions, please explain further on the back of this page.

## Firefighter Experience & Certifications

Previous Fire Service Experience:

YEAR(S) SERVED	DEPARTMENT NAME AND LOCATION	CHIEF'S NAME	PHONE NUMBER
YEAR(S) SERVED	DEPARTMENT NAME AND LOCATION	CHIEF'S NAME	PHONE NUMBER
YEAR(S) SERVED	DEPARTMENT NAME AND LOCATION	CHIEF'S NAME	PHONE NUMBER
YEAR(S) SERVED	DEPARTMENT NAME AND LOCATION	CHIEF'S NAME	PHONE NUMBER

Certifications:

<b>FIRE SERVICE</b>	
<b>EMS/FIRST AID</b>	INCLUDE LICENSE NUMBERS & EXPIRATION DATES

What Special Skills Do You Have That Would Be Of Benefit To The Department? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why Do You Wish To Join The Rolla Rural Fire District? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PHYSICAL EXAMINATION FOR  
ROLLA RURAL FIREFIGHTER APPLICANT**  
(TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER PRIOR TO BEING FULLY ACCEPTED)

APPLICANT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ TPR: \_\_\_\_\_ B/P: \_\_\_\_\_

MEDICAL HISTORY: (PLEASE DESCRIBE ALL MAJOR ILLNESSES, OPERATIONS, INJURIES, DRUG ALLERGIES, ETC.)

\_\_\_\_\_

MENSES: \_\_\_\_\_

EYES: VISION: R \_\_\_\_ L \_\_\_\_ WITH GLASSES OR CORRECTIVE LENSES: R \_\_\_\_ L \_\_\_\_

NOSE: \_\_\_\_\_ THROAT: \_\_\_\_\_ SINUSES: \_\_\_\_\_

ORTHOPEDIC CONDITIONS: \_\_\_\_\_

HEART: \_\_\_\_\_

LUNGS: \_\_\_\_\_

ABDOMEN: \_\_\_\_\_ HERNIA: \_\_\_\_\_

ARE THERE ANY RESTRICTIONS ON PHYSICAL ACTIVITIES? YES \_\_\_\_ NO \_\_\_\_ LIMITED: \_\_\_\_\_

IDENTIFY & DESCRIBE: \_\_\_\_\_

HAS THIS INDIVIDUAL EVER RECEIVED TREATMENT OR HOSPITALIZATION FOR EMOTIONAL PROBLEMS?

YES: \_\_\_\_ NO: \_\_\_\_ IF YES, WHEN/WHERE: \_\_\_\_\_

DO YOU BELIEVE THIS INDIVIDUAL IS SUITABLE BOTH PHYSICALLY AND EMOTIONALLY FOR THE SAFE PRACTICE IN THE FIRE SERVICE?

YES: \_\_\_\_ NO: \_\_\_\_ IF NO, WHY? \_\_\_\_\_

IS THIS PERSON ON ANY SPECIFIC DRUGS FOR HEALTH MAINTENANCE?

YES: \_\_\_\_ NO: \_\_\_\_ IF YES, NAME(S) OF MEDICATION: \_\_\_\_\_

WILL THIS/THESE DRUGS INTERFERE WITH HIS/HER PERFORMANCE AS A FIREFIGHTER?

YES: \_\_\_\_ NO: \_\_\_\_ IF YES, WHY? \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER PRINTED NAME: \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_