Atlantic County Fire Academy
5033 English Creek Avenue
Egg Harbor Township, NJ 08234

REGISTRATION FORM - FIREFIGHTER I

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION
Spring ____ Summer ____ Fall ____

STUDENT'S FULL NAME: ____
First Middle Last

HOME ADDRESS: ____

____
City County State Zip

HOME TELEPHONE #: (_____)____________ CELL PHONE #: (_____)______________.

DATE OF BIRTH: ____/____/______, AGE: ________, SS #: ______/_____/___________

DRIVER'S LICENSE #: ___________________________

T-SHIRT SIZE: _________, GOLF SHIRT SIZE: __________

EDUCATION: HIGHEST GRADE LEVEL COMPLETED ___________________________

FIRE COMPANY NAME: ____

FIRE COMPANY ADDRESS: _______________________CITY______________ZIP______

FIRE COMPANY TELEPHONE #: (____)_______________FAX #: (____)______________.

Medical Form Attached: Yes _____ No _____ Date: ______________

NOTE: Attach a copy of a completed and signed medical form to this registration form. Forms can be found in the current course announcement.

Check, money orders, or company vouchers are to be made payable to the **Atlantic County Fire Academy** and mailed to the above address.

The applicant has read this form and by his/her signature agrees to abide by the regulations and age requirement of 18 established by the Atlantic County Firefighters' Association.

____
Signature of Applicant Date

CERTIFICATION

I, _________________________________, ______________________ of
Print Name Title

____________________________________, do hereby certify that the information contained in
Company/Department
this registration form is true and accurate. I also confirm that the applicant is covered by a

Worker's Compensation Insurance Policy.

____
Signature of above Fire Chief or his Designee Date

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MEDICAL FORM – FIREFIGHTER I

To be filled out by a physician licensed in the State of New Jersey and returned with the Firefighter I Registration Form. Physical examination guidelines and Firefighter Performances are listed below. All sections of the physical must be properly filled out or the application will be returned.

PLEASE PRINT

NAME: ____ ____________
First Initial Last Sex

Age: _____ **Height:** _____**Ft.** _____**In. Weight:** ________ **lbs. Hearing:** _________

Eyesight Left: _________ **Right:** _________ **Both (corrected):** _________ **BP:** ________

PHYSICAL EXAMINATION GUIDELINES

1. **EYES: Must be 20/30 corrected (with glasses, contacts, or surgical procedures)**
2. **HEARING: Loss of hearing acuity so as to be unable to perceive sounds within normal voice range with or without hearing aid.**
3. **NOSE: Any significant nasal obstruction to free breathing not subject to correction by surgery.**
4. **MOUTH: Conditions with impair ability to communicate.**
5. **NECK: Problems resulting from (a) Goiter; (b) Limited range of motion; which prohibits range of motion, extension or free movement of neck; (c) Tracheotomy – existing openings at the lower portion of the neck connecting the windpipe to the outside environment for the purpose of easy breathing.**
6. **PULMONARY: Problems resulting from loss or removal of lung: (a) any pulmonary disorder which would limit the applicants ability to perform; (b) Pulmonary function test below normal; (c) Chronic Obstructive Pulmonary Disease/Asthma.**
7. **CARDIO PULMONARY SYSTEM: Problems resulting from heart disease or cardiomegaly.**
8. **PERIPHERAL VASCULAR SYSTEM: Problems resulting from: (a) Varicose veins; (b) Aneurysms; (c) Lymph edema; (d) Thrombophlebitis; (e) Arteriosclerosis Obliterans; (f) Buerger's Disease; (g) Raynaud's Disease; (h) Arterio-Venous Fistula; (i) High Blood Pressure, not able to be corrected or controlled by medication. Acceptable blood pressure reading should be as follows: Systolic not higher that 150 but not lower than 90. Diastolic maximum should be 100 mmhg, minimum 50 mmhg.**
9. **ABDOMEN: Problems resulting from a (a) Organomegaly; (b) Signs of tenderness in an area; (c) Presence of masses such as hernias of various types.**
10. **GENITOURINARY SYSTEM: Problems arising from (a) Presence of abnormal masses; (b) Abnormal discharges from any of the orifices; (c) Active venereal diseases; (d) Parasitic diseases; (e) Varicocele and Varices; (f) Hydrocele.**
11. **MUSCULO-SKELETAL SYSTEM: Problems arising from (a) Congenital malformation; (b) Limitation of Motion; (c) Weakness; (d) Impairment or absence of one or more of the digits on either or both hands; (e) Impairment of function of the hands; (f) Missing toes if it interferes with ambulation; (g) Deformities of the spine, pelvis or extremities.**
12. **OTHERS: Problems arising of (a) Disqualification for psychiatric conditions must be determined by local agencies; (b) Allergic conditions which are chronic and incapacitating; (c) Severe anemia; (d) Active Peptic Ulcer; (e) Diabetes; (f) History**

of epilepsy or seizures other than documented febrile convulsions in childhood; (g) alcoholism or drug addiction; (h) Removal of vital organs; (i) Any other condition not listed above which would render the eligible incapable of performing their duties as a firefighter.

THESE MEDICAL GUIDELINES ARE TO BE FOLLOWED BY THE PHYSICIAN PERFORMING THE EXAMINATION. ANY ABNORMAL FINDINGS THAT WOULD PROHIBIT THE APPLICANT FROM OPERATING IN A SAFE MANNER OR PERFORMING ANY OF THE LISTED PERFORMANCES ARE GROUNDS FOR THE APPLICANT TO BE REJECTED.

FIREFIGHTER PERFORMANCIES

The following are a list of job performances that will be performed by the applicant during his/her training and throughout the course of his/her firefighting career.

1. **Ability to raise, climb and work off of ladders above the ground.**
2. **Ability to wear a Self Contained Breathing Apparatus (SCBA) and operate in an IDLH atmosphere including smoke and high heat environments.**
3. **Ability to work in a vision obscured environment.**
4. **Ability to hold and handle a charged hose line during extinguishment of a fire.**
5. **Ability to hold and handle hand tools, power tools and power saws during forcible entry, ventilation and firefighting operations.**
6. **Ability to crawl, walk, lift heavy objects and work in a stress-induced environment while wearing protective clothing and equipment weighing approximately 50 lbs.**
7. **Ability to hear radio transmission and perform two-way communication.**
8. **Ability to rescue and lift civilian victims and other firefighters in need of help.**

I CERTIFY AS A PRACTICING PHYSICIAN IN THE STATE OF NEW JERSEY, THE APPLICANT IS FREE FROM ANY ACUTE OR CHRONIC DISEASE AND HAS NO SHYSICAL DEFECTS THAT WOULD HINDER HIS/HER ABILITY TO PERFORM THE DUTIES OF A FIREFIGHTER.

DATE EXAMINED___________ EXAMINED AT_________________________________

_________________________________ _____________________________
PHYSICIAN'S PHONE NUMBER PRINT PHYSICIAN'S NAME

____
SIGNATURE OF PHYSICIAN

ATLANTIC COUNTY FIRE ACADEMY
MASK FIT TEST & MEDICAL
CERTIFICATION

Directions:

1.) Print your name and fire company and have your Fire Chief sign the Certification below prior to you participating or attending any live fire evolution or IDLH atmosphere requiring the use of a SCBA at Atlantic County Fire Academy.

2.) **Do not** fill out the rest of this form at this time. Bring it with you to the Fire Academy. The Lead Instructor at the Fire Academy will instruct you when to complete it.

FIRE CHIEF CERTIFICATION

____________________________ ____________________________
Name of Firefighter Name of Fire Company

The above firefighter has received and passed a SCBA Mask fit test and the results allow him/her to wear an SCBA during firefighting operations and IDLH Atmospheres.

Date: _____/_____/_____ ____________________________
Signature of Fire Chief/Authorized Designee

STUDENT/PARTICIPANT CERTIFICATION

I ____________________________ of ____________________________
(Print your Name) (Name of Fire Company)

hereby certify that I have received and passed at SCBA mask fit test in the last 12 months and that the SCBA Mask that I will be using during the live fire training today is the type and size that I was fit tested with.

I further certify that I understand that standing up in a live fire evolution may result in me receiving burns to my body.

I further certify that I have no known medical problem or medication that would prevent me from participating in any live fire evolution or IDLH atmosphere.

Date: _____/_____/_____ ____________________________
Signature of Student/Participant

____________________________ ____________________________
Type of Training Lead Instructor Signature