RINER VOLUNTEER RESCUE SQUAD

Membership Application

TO ALL MEMBERSHIP APPLICANTS:

Thank you for your interest in membership with the Riner Volunteer Rescue Squad (RVRS). RVRS is dedicated to providing the community with the highest quality of emergency medical care.

In order to assure that your application is processed in a timely manner, please be sure that all of the following are completed.

- All sections of the application must be completed and signed (including Drivers License copy).
- Attach copies of all EMS related certifications (if applicable).
- Please inform any references used that a completed electronic reference form will need to be submitted in a timely manner.
  - Family members should not be used as references. For student applicants, a teacher/ professor is acceptable.
  - A valid phone number is required for each reference in the event the membership committee needs further information.
  - Incomplete or erroneous information will delay the processing of your application.
- Completed applications should be saved and e-mailed or mailed to: **membership@rinerrescue.org or Attn: First Lieutenant Riner Volunteer Rescue Squad P.O. Box 858, Riner, VA 24149**.
- A copy of your Immunization history will need to be provided with your application.

"Proudly Serving the Community of Riner Since 2011"

RINER VOLUNTEER RESCUE SQUAD

Membership Application

APPLICANT			
Last Name	First	M.I.	DOB
Street Address		Apt. #	
City	State	ZIP	
Phone	E-mail		
Membership Category	Active Associate Driver Only (EVOC certified) Junior(Minor)		

BACKGROUND
Do you have a legal right to work in the United States? YES NO State Number
Do you have a valid driver's license? YES NO State Number
Have you ever been convicted of a crime? YES NO If yes, attach explanation
Have you ever been convicted of driving while intoxicated or Under the Influence? YES NO If yes, attach explanation
Have you ever been denied or terminated membership from a public safety agency? YES NO If yes, attach explanation
Have you ever been dismissed or forced to resign from any work or volunteer position? YES NO If yes, attach explanation

EDUCATION		
High School	Address	
From To	Did you graduate? YES NO	Degree
College	Address	
From To	Did you graduate? YES NO	Degree
Other	Address	
From To	Did you graduate? YES NO	Degree

CERTIFICATIONS	
List relevant certifications. Attach copies. (ie: EMT, NREMT, EVOC, CPR, ACLS, PALS, etc.)	
Certification	Expiration

EMPLOYMENT		
List most current/recent employment		
Company		Phone
Address		
Position		Supervisor
From To	Reason for Leaving	

EXPERIENCE		
List all prior experience with volunteer fire, EMS, and other public safety organizations.		
Agency		Phone
Address		
Position		Chief
From To	Reason for Leaving	
Agency		Phone
Address		
Position		Chief
From To	Reason for Leaving	
If you have additional experience, please attach.		

REFERENCES	
List three references. Do not include relatives or employers.	
Full Name	Phone & E-Mail
Address	Relationship
Full Name	Phone & E-Mail
Address	Relationship

STATEMENT

I hereby certify that every statement I have made on this application and supporting documents is true and complete. I understand that any false information or omission may disqualify me from further consideration for membership and may result in my immediate discharge if discovered at a later date. I understand that if this application is incomplete, it will not be processed.

I authorize the Riner Volunteer Rescue Squad to investigate, without liability, all statements contained in this application and supporting materials. I also authorize references, employers, public safety agencies, and others, without liability, to make full responses to any inquiries in connection with this application.

I understand that the use of illegal drugs is strictly prohibited and grounds for immediate termination. The use of alcohol or misuse of prescription drugs prior to or during duty is a serious violation punishable up to and including termination. I understand that I may be subject to random drug testing at any time.

My signature authorizes drug screening, investigative reports, criminal history and driving record checks, reference checks, and physical examination if required.

Signature Date

MONTGOMERY COUNTY VIRGINIA
EST. 1776

Christiansburg, Virginia

National Background Screening Consent Form

Applicant's **Legal** Name (printed): _____
First Name Full Middle Name Last Name

Social Security Number _____ Date of Birth _____ Gender_____

Applicant's Address _____

City_____ State_____ Zip _____

Email:_____ Phone Number _____

I,_____, authorize and give consent for the above named Organization to obtain information regarding myself. This includes the following:

- Local & National Criminal background records/information
- All 50 State Sex Offender Registries
- Full Address Trace
- Social Security Verification

I, the undersigned, authorize this information to be obtained (in writing, electronically, by fax, or via telephone, etc.) in connection with my application. Any person, firm or organization providing information or records in accordance with this authorization is released from any and all claims of liability for compliance. Such information will be held in confidence in accordance with Montgomery County Human Resources policies and applicable federal/state/local guidelines.

I further understand that a criminal conviction may not necessarily be a barrier or preclude employment, and any conviction will be considered using the Equal Employment Opportunity Commission "Green Factors" considering the duties of the role with the type/nature of conviction, type and number of convictions, time since conviction without recidivism, and whether my hire/transfer or other employment action would pose an unacceptable level of risk to the organization. If information comes back as deemed unsuitable for the role in the opinion of the Director of Human Resources, I understand that it can negatively impact my employment, up to and including termination.

Print Name: _____ Date_____ Signature: _____

Department Requesting Backgroundscreening: _____

Questions? Call Montgomery County Human Resources (540-394-2007)

Riner Volunteer Rescue Squad
4171 Riner Rd Riner VA 24149
(540) 381-6043 • Fax (540) 382-6254
E-Mail: info@rinerrescue.org

Driving Record and Vaccine Record

Due to the degree of work that we do even as volunteers, the State of VA and the VA Office of EMS requires that we keep an up-to-date Vaccine / Hep -B and Driving Record on file for each of our members. Below you will find some directions on how to obtain this information. We understand that some members may choose not to receive vaccinations and if this the case with you, we simply will need you to fill out a Vaccine Declination Form.

Riner Volunteer Rescue will now pull your driving record for you at no cost. To authorize this, please sign the below:

I, _____, hereby grant Riner Volunteer Rescue to obtain a copy of my Driver's License and any associated records within.

_____ _____
Signature Date

To receive your Vaccine Records,

1. If you have or see a PCP, they may be able to print it off for you if it is in their system.
2. The Local Health department where you received your vaccines normally keeps these on file.

All you need to do is call them or some States / Localities have your records on their website that you can print off.

Thank you,
Jessica Roop
1st Lieutenant - Membership
Riner Volunteer Rescue Squad

Riner Volunteer Rescue Squad
4171 Riner Rd Riner VA 24149
(540) 381-6043 • Fax (540) 382-6254
E-Mail: info@rinerrescue.org

Drug & Alcohol Policy Acknowledgement

I acknowledge that I have received and reviewed a copy of the Riner Volunteer Rescue Squad's Alcohol and Drugs Policy and Procedures. By signing below, I am agreeing to the terms and conditions set forth in this policy and acknowledge that any breach of this shall result in immediate suspension and possible termination from Riner Volunteer Rescue Squad.

_____ _____

Printed Name Date

_____

Signature

Riner Volunteer Rescue Squad
4171 Riner Rd. Riner, VA 24149
540-381-6043

LINE OF DUTY ACT

Section 9.1 – 400 408, of the Code of Virginia, is the Line of Duty (LODA) act ("the Act"). The Act provides eligible public safety employees, recognized volunteers and their spouses and dependent children benefits if the eligible public safety officer dies or is disabled in the line of duty. Benefits include a death benefit and payment of health insurance premium. There is a five-year statute of limitations under Virginia law in which the disabled person or the spouse/dependent of a deceased or disabled person shall present his/her claim LODA benefits.

Acknowledgment of Awareness of Line of Duty Act Benefits

I hereby acknowledge that I have received and read a copy of the Line of Duty Act and understand that a five-year statute of limitations applies to claims for LODA benefits. Questions regarding LODA should be directed to the Commonwealth's Department of Accounts at (804) 786-1856. Another LODA resource is www.valoda.org

_____ _____
Employee/Volunteer Signature Employee/Volunteer Printed Name

_____
Date

APPLICATION FOR MEMBERSHIP

COMMONWEALTH OF VIRGINIA VOLUNTEER FIREFIGHTERS' & RESCUE SQUAD WORKERS' SERVICE AWARD PROGRAM

Clear Form

PART A. MEMBER INFORMATION

2. Name (First, Middle Initial, Last)		
3. Address (Street, City, State and Zip+4)		
4. Social Security Number	**5. Date of Birth**	**6. Phone Number**

7. Department/Squad Information

❑ Fire ❑ Rescue

Department/Squad Name: _____

Location/County: _____

Date Service Began with this Department: _____

Beneficiary: Unless otherwise indicated on VOLSAP Form 4, the beneficiary shall be the member's spouse. If none, the member's living children equally; if there are no children, the member's heirs-at-law as may be determined by the VOLSAP Board, or the member's estate, if it is administered and there are no heirs, or such other beneficiary(ies) as the member may name on a form prepared by the board, signed by the member and filed in a manner prescribed by the board.

❑ Check here if Beneficiary Election Change Form (VOLSAP-4) is attached.

PART B. MEMBER CERTIFICATION (Check appropriate block)

❑ Initial enrollment in the VOLSAP Fund. (Requires completed membership application and quarterly contribution.)

❑ Prior member applying to rejoin. (Requires completed membership application and quarterly contribution. An administrative fee of $25 will be deducted from the member's account.)

❑ Prior member in good standing who notified the board of discontinuance of contributions, applying to rejoin. (Requires completed membership application and quarterly contribution; no administrative fees deducted.)

Important: Membership is effective on the date this application and contribution are received in good order by the Plan Administrator. Funds are invested within five days of the end of the quarter. If credit for any prior service with a department is desired, the Application to Purchase Prior Service (VOLSAP Form 3) must be completed. Contributions must be kept current. Members who become six months delinquent will forfeit their membership.

_____ _____

Member Signature Date

PART C. DEPARTMENT/SQUAD CERTIFICATION

I certify the above named applicant is a current member of the department/squad named above and is eligible to become a member of the VOLSAP Fund.

_____ _____

Authorized Signer's Printed Name Date

_____ _____

Authorized Signer's Title Daytime Phone Number

_____

Authorized Signature

Send completed form and contributions to:

Wells Fargo IRT Texas Service Center/VOLSAP
P.O. Box 2577
Waco, TX 76702-2577

Email questions to:
volsap@varetire.org

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800) 233-1957 or (717) 741-0911
www.vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐	Group Term Life	**Policyholder** Montgomery Co. Fire & Rescue	**Policy Number**	CVT301295R
☐		**Policyholder**	**Policy Number**	
☐		**Policyholder**	**Policy Number**	
☐		**Policyholder**	**Policy Number**	
☐	**Other**			
☐	**Other**			

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Date of Membership:**	**Social Security Number:** / /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class ☐ **Mark if additional beneficiaries are listed on a separate paper and attached.** **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	**Relationship to Insured**	**Percent**
One Beneficiary of a class Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.
** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.