# AVOCA FIRE DEPARTMENT
# STANDARD OPERATING PROCEDURES

## SUBJECT: QUALIFICATIONS AND REQUIREMENTS TO BECOME A FIREFIGHTER FOR THE AVOCA FIRE DEPARTMENT

A. Qualifications
   a. 18 years of age
   b. Valid Arkansas drivers license
   c. Live within a reasonable distance of Avoca Fire Department district. Location to be approved by one of the chiefs.
   d. Avoca Fire Department is a Equal Opportunity Employer and will not discriminate against sex, race, religion or disability.
   e. All requirements can be found in Department of Emergency Management S.O.P. Manual.

B. Requirements
   a. Fill out application and all other county paperwork to be provided by AFD.
      i. Employment application. S.S. CARD
      ii. Benton County driving form.
      iii. AFD Code 3 response form.
      iv. Drug and alcohol use form.
      v. Copy of Arkansas drivers licence.
      vi. Agree to background check if needed.
   b. Attend 4 training sessions held on 1st Saturday at 8:00 a.m. and 3rd Thursday at 19:00.
      i. After completing 4 sessions, the captain's and firefighter's will vote the new firefighter on or off the Fire Department.
      ii. Chiefs can reverse the decision of the vote at any time if they feel that it is for the better of the Avoca Fire Department.
      iii. If a new member is voted on the Fire Department they will be issued a Fire Department pager. They are now allowed to respond code 1 to Fire Department calls. All new firefighters may not respond to EMS calls unless they are medical certified or with a medical certified member of the Avoca Fire Department.
      iv. After becoming a member of the Avoca Fire Department, all new members will be put on a 90 day probation period. In that period the chief's may dismiss the new member for anything that they see may be harmful for themselves, other firefighters, public, victim's, or reputation of the Avoca Fire Department.

**751 cont.**

v. A new member will not be issued firefighting gear until that member has met the minimum requirements listed in SOP 732 section A unless otherwise approved by the chiefs.
vi. No red lights and siren can be used until approved by the chiefs.
vii. All members are required to complete 6 hours per quarter training.

# *Benton County Department of Emergency Management and Homeland Security*

**www.co.benton.ar.us**

Date: __________

**Section I: Personal Information**

Name: ______________________________________ Date of Birth: ______________
Last First Middle Month Day Year

Social Security Number: ______________ Driver's License Number: ______________

Current Address: ______________________________________
Number Street Apt City State Zip Code

Mailing Address (if different): ______________________________________

Home Phone Number: ______________ Work Phone Number: ______________
Alternate Phone Number: ______________

Name of Spouse: ______________

Agency(s) Applying For:

___ ARES – RACES
Call Sign: ______________

___ Fire Protection Association
Department Name: ______________

___ Department of Emergency Management and Homeland Security

___ Search and Rescue

___ Water Rescue

Have you served or currently serve with any other emergency service agency? ___ Yes ___ No
Agency: ______________ Dates of Service: __________ to __________

**Section II: Military History**

Branch of Service: ______________ Serial Number: ______________
Enlistment: __________ Discharge: __________ Discharge Type: ______________
Rank when discharged: ______________ Are you a member of a Reserve Unit? ___ Yes ___No

# Benton County Department of Emergency Management and Homeland Security

www.co.benton.ar.us

If yes, provide unit name: ______________________________

**Section III: Employment History**

| Employer | City/State | Supervisor | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Section IV: Educational History**

| High School | City/State | From | To | Diploma or GED |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| **College and/or Trade Schools** | **City/State** | **From** | **To** | **Degree** |
| 1. | | | | |
| 2. | | | | |
| **Specialized/Technical Training** | **City/State** | **From** | **To** | **Certificate** |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Use Additional Sheets if Necessary

# *Benton County Department of Emergency Management and Homeland Security*

www.co.benton.ar.us

**Section V: Residence History**

| Street Address | City/State/Zip | From | To | Landlord |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section VI: References**

| Name | Occupation | Address | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Section VII: Questionnaire**

Have you ever been convicted with any violation or crime, including traffic tickets?
___ Yes ___ No If yes, explain:

Has your driver's license ever been revoked or suspended? ___ Yes ___ No If yes, explain:

Why do you wish to become an emergency service volunteer?

# Benton County Department of Emergency Management and Homeland Security

www.co.benton.ar.us

I hereby certify that all statements by me in this application are true, complete, and correct. I understand false statements herein are sufficient grounds for rejection of this application. If approved for service, I agree to abide b all of the provisions of Benton County Emergency Management and Homeland Security's policy, Benton County policy, and the subsidiary for which I am applying.

Signature of Applicant ______________________ Date ____________

**Applicant Instructions**
Complete application in its entirety. (print or type)
Return application to the department(s) for which you are applying.

**Department Instructions**
Interview applicant to determine eligibility.
Approve or decline applicant. (see administrative section)
Maintain a copy of application for your records.
Return original to Department of Emergency Management for background check and final disposition.

**FOR ADMINISTRATIVE USE ONLY**

| Interviewer | Date | Comments |
|---|---|---|
| | | |
| | | |
| | | |

Date Application Received: ____________

**Department Administrative Action**
Date of Administrative Action: ____________
Type of Action: Approved ___
Declined ___

# *Benton County Department of Emergency Management and Homeland Security*

www.co.benton.ar.us

**County Administrative Action**
Date of Administrative Action: ____________
Type of Action: Approved ___
Declined ___

**Authorization to Release Information**

I, ________________________, am a volunteer applicant with the Benton County Department of Emergency Management and Homeland Security. In order to process my application, certain information must be made available to the Department. This information is for my benefit. I hereby authorize, request, and direct educational institutions; my references; my employers (past and present); medical institutions and doctors; any other person, institution, or organization; and all governmental agencies, law enforcement agencies and instrumentalities (local, state, federal, or foreign); wherever said individuals or organizations are situated, to release to the Director or to any representative thereo the following information, including but not limited to any document, information, record, or file that he deems material to the processing of my application for employment. Said information can be furnished if the request therefore is made i person or in writing.

Pursuant to ARK. CODE ANN. SECTION 12-12-1009, I hereby authorize the Benton County Department of Emergency Management and Homeland Security (the "department" to obtain conviction information from any local, state, federal or foreign agency, registry or repository. I understand that conviction information shall only be used for the purpose of employment with the department and that conviction information may not be redisseminated.

________________________________ ____________
Signature of Applicant Date

# Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization ______________________ State ________

Member's /Employee's Name ______________________

Member's Date of Birth ____________ Date Member Joined Organization ____________

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed

Primary (Please refer to back of form for examples)

Beneficiary Name ____________ Relationship ________ Date of Birth ________ Share ______%

Name ____________ Relationship ________ Date of Birth ________ Share ______%

Contingent Beneficiary Name ____________ Relationship ________ Date of Birth ________ Share ______%

Name ____________ Relationship ________ Date of Birth ________ Share ______%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature ______________________ Date ____________

**This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.**

C01-008A (11/05)

Please Type or Print in Ink:

EE#________________ (LOPFI USE ONLY)

# ARKANSAS LOCAL POLICE AND FIRE RETIREMENT SYSTEM (LOPFI)
## Membership Application

Last Name ______ First Name ______ Middle Initial ______ S.S. Number ______

Home Address: ______ Street ______ City ______ State ______ Zip Code

Birth Date: ______ ☐Male ☐Female Name of Department ______

______ Date of Enrollment ______ Department Classification (Police / Fire)

☐ Paid Employee ☐ Volunteer S.S. Coverage with LOPFI Employer? ☐ YES ☐ NO

1. Have you previously been employed by this city or another city, and as a result of such employment been a member of LOPFI? ☐ YES ☐ NO. If yes, list name of city and period of employment. City: ______
From: ______ Month / Year To: ______ Month / Year

2. Have you previously been employed by this Employer and as a result of such employment were a member of a local Firemen's or Policemen's Relief Fund? ☐ YES ☐ NO. If Yes, list department and period of employment.
Department ______ (Police / Fire) From: ______ Month / Year To: ______ Month / Year

3. Have you previously been an employee covered by any of the following retirement systems: APERS, Teachers, State Highway, State Police, Judicial, Higher Education, or Vo-Tech Education? ☐ YES ☐ NO.
If Yes, list employer and period of employment.
Employer ______ From: ______ Month / Year To: ______ Month / Year

4. NOMINATION OF BENEFICIARY: I hereby direct LOPFI to pay my accumulated member contributions or the benefit which may be payable in the event of my death before retirement to:

______ (Print Full Name of Primary Beneficiary) ______ Street ______ City ______ State ______ Zip Code

My ______ (Relationship to Applicant) Whose Birthdate is ______ S.S. Number ______

OTHERWISE TO: ______ (Print Full Name of Contingent Beneficiary) ______ Street ______ City ______ State ______ Zip Code

My ______ (Relationship to Applicant) Whose Birthdate is ______ S.S. Number ______

If you wish to nominate more than one contingent beneficiary to share equally in your accumulated member contributions in the event of your death, please list their name and address on back of this form.

I DO HEREBY AUTHORIZE MY EMPLOYER TO MAKE ANY NECESSARY PAYROLL DEDUCTIONS FROM MY SALARY AS AUTHORIZED BY A.C.A. 24-10-101, ET. SEQ., AS AMENDED, AND DECLARE THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS APPLICATION MUST BE SIGNED BY APPLICANT AND EMPLOYER REPRESENTATIVE.

______ Signature of Employer Representative DATE ______ Signature of Member DATE

Please mail original copy to:
LOPFI
620 W. 3rd, Suite 200
Little Rock, Arkansas 72201-2223

 **White Copy - LOPFI** **Yellow Copy - EMPLOYER**

# BENTON COUNTY

## STATE OF ARKANSAS

Gary D. Black
County Judge

215 E. Central
Bentonville, AR 72712
Office (479) 271-1000

J. Travis Harp
Assistant County Administrator

## DRIVER QUESTIONNAIRE FORM

Has your operator's license/registration ever been suspended or revoked? _____

Have you ever had a conviction involving drugs, alcohol, reckless driving, homicide, manslaughter, or assault arising out of the operation of a motor vehicle? _____

Have you been involved in any motor vehicle accidents in the last five years? _____

Have you received any driving citations (other than parking or those listed above) in the past five years? _____

I ____________________________ agree to only operate the county vehicles when in full possession of my faculties; when the vehicle is in safe mechanical conditions; in accordance with all traffic laws, signals and markings; and in a courteous manner at all times.

I ____________________________ hereby authorize any state motor vehicle department to disclose information regarding my driving record to Benton County.

I ____________________________ understand that I am not to use this vehicle for personal use as stated in the Benton County Employment Policy.

*I certify the above answers given are true and agree if any information is falsified it is caused for dismissal.*

______________________________
Employee's Name (Printed)

______________________________
Employee's Signature

Today's Date ________________

______________________________
Witness Signature

BENTON COUNTY EMERGENCY SERVICES
215 East Central, #7 • Bentonville, Arkansas 72712
479-271-1004

# ANNUAL MEDICAL STATEMENT

NOTE: This form is designed to provide the individual in charge of all volunteer personnel a complete history of physical status as of the date indicated, without the need for expensive physical examinations. This form must be completed on an annual basis. If any of the questions are answered "Yes," be sure that the answer is fully explained.

## Questions:

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Full Time Occupation: ____________________

Position/Title: ____________________

SSN or IDN: ____________________

1. Date of Birth: (Month) ______ (Day) ______ (Year) ______

2. Eyesight:

| | Yes | No |
|---|---|---|
| a. Have you lost use of either eye? R__ L__ | ☐ | ☐ |
| b. Is peripheral (side) vision restricted? | ☐ | ☐ |
| c. Are you color blind? | ☐ | ☐ |
| d. Do you have (or have you ever had) cataracts? | ☐ | ☐ |
| e. Are actual deficiencies corrected by glasses or contact lenses? | ☐ | ☐ |

f. Date of last eye examination: ____________________

3. Hearing:

| | Yes | No |
|---|---|---|
| a. Do you have difficulty hearing normal conversation? | ☐ | ☐ |
| b. Do you use a hearing aid? | ☐ | ☐ |

4. Diabetes:

| | Yes | No |
|---|---|---|
| a. Have you ever been treated for diabetes? | ☐ | ☐ |

b. Describe current medication and dosage, if any, and method of administration under "remarks."

c. Date of latest blood sugar test: ____________________

5. Heart:

| | Yes | No |
|---|---|---|
| a. Have you ever been treated for heart disease? | ☐ | ☐ |

b. Describe condition: ____________________

c. Describe current medication and dosage, if any, under "remarks."

| | Yes | No |
|---|---|---|
| d. Do you have a pacemaker: | ☐ | ☐ |

e. Date of last treatment or check-up: ____________________

6. Epilepsy:

| | Yes | No |
|---|---|---|
| a. Have you ever been treated for epilepsy? | ☐ | ☐ |

b. If "Yes," when was your last seizure? ____________________

c. Describe current medication and dosage, if any:

7. Blood Pressure:

| | Yes | No |
|---|---|---|
| a. Have you ever been treated for high blood pressure? | ☐ | ☐ |

b. If "Yes," when were your treated? ____________________

c. What was your last reading? ____________________

d. Describe current medication and dosage, if any, under "remarks."

## Remarks:

NOTE: If any question is answered "Yes," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

Questions:

8. Limbs:

| | Yes | No |
|---|---|---|
| a. Have you lost an arm or leg? | ☐ | ☐ |
| b. Have you lost the use of an arm or leg? | ☐ | ☐ |
| c. Does your vehicle have special controls? | ☐ | ☐ |
| d. If "Yes," describe under "remarks." | | |

9. Miscellaneous:

| | Yes | No |
|---|---|---|
| a. Have you ever had (or been treated for) convulsions? | ☐ | ☐ |
| b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| c. Have you ever had any fainting spells? | ☐ | ☐ |
| d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| e. Have you ever had, or been treated for, loss of equilibrium? | ☐ | ☐ |
| f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| g. Have you ever been treated for alcohol or drug abuse? | ☐ | ☐ |
| h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| i. Have you ever been treated for mental illness? | ☐ | ☐ |
| j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |

10. What is the date of your last physical examination? ____________

11. Are there any restrictions posted on your vehicle operator's License? ☐ ☐

12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?

13. When and for what purpose, did you last consult a doctor?

____________________________________________

14. Full name, address and phone number of your personal physician:

____________________________________________

____________________________________________

____________________________________________

Remarks:

The answers to the above are complete, accurate and true to the best of my knowledge.

____________________________________________
(Signature)

______________________
(Date)

Benton County OES Form 905 (Revised October 1, 1996)
(All other forms are obsolete and will not be accepted.)

# ARKANSAS STATE POLICE

ASP-122
(Rev. 09/07)

## Identification Bureau
## Individual Record Check Form

Procedure For Criminal History Check

1. The ASP form 122, Individual Record Check Form, must be completed in its entirety.
2. A check or money order in the amount of $25.00 made payable to the Arkansas State Police, must be included.
3. If the request is presented in person, the person requesting must present a photo I.D. issued by a government agency.
4. If the request is made by mail, the signature on the ASP form 122 must be notarized.
5. If the request is made by mail, a self-addressed envelope with sufficient return postage must be included.
6. If the request is made in person at our office by a third party, such as an employment agency or employer, the ASP form 122 must be notarized.
7. If the request is required by a particular licensing entity as mandated by state law, such as teachers, health care or police, please contact the appropriate licensing entity to obtain the proper forms and be advised of the correct procedure to obtain a criminal history.

Send requests to:

Arkansas State Police
Identification Bureau
#1 State Police Plaza Dr.
Little Rock, AR 72209

To contact the Identification Bureau, you may call 501-618-8500.

SEE OTHER SIDE FOR APPLICATION

# ARKANSAS STATE POLICE

ASP-122
(Rev. 09/07)

## Identification Bureau
## Individual Record Check Form

Full Name: ______ ______ ______ / ______
First Middle Last Name Maiden/Other

Date of Birth: ______ State of Birth: ______ Race: ____ Sex: ____
(Month/Day/Year)

Social Security #: ______ Driver's License #: ______
State

Mailing Address: ______
Street City State ZIP

Daytime Phone #: (____) ______

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY:

Name: ______
(First/MI/Last Name) or Full Name of Agency

Mailing Address: ______
Street City State ZIP

Signature: ______ Date: ______
(First/MI/Last Name) (Month/Day/Year)

**(NO REQUEST WILL BE PROCESSED WITHOUT A NOTARIZED SIGNATURE)**

STATE OF ______
§
COUNTY OF ______

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this the ______ day of ______, 20 ______ .

______
Notary Public

☐ 82004 State Record Check

☐ 82005 State Record Check