

# OKANOGAN COUNTY FIRE DISTRICT #6

P.O. BOX 895 • WINTHROP, WA 98862 • PHONE (509) 997-2981 • FAX (509) 997-2982



Commissioners  
Jerry Palm - Chair  
Darold Brandenburg  
Les Stokes

Chief  
Cody Acord  
[cacord@okanogancountyfd6.com](mailto:cacord@okanogancountyfd6.com)

Secretary  
Mark Crum

**Answer all questions in the space provided. If more space is need, please attach additional pages.**

NAME \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PHYSICAL ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ CELL \_\_\_\_\_

## PERSONAL

AGE \_\_\_\_\_ BIRTHDATE (MM/DD/YYYY) \_\_\_\_\_ MARITAL STATUS:  Single  Married

SOCIAL SECURITY # \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ HAIR COLOR \_\_\_\_\_ EYE COLOR \_\_\_\_\_

WASHINGTON STATE  
DRIVER'S LICENSE NO. \_\_\_\_\_

RESTRICTIONS OR  
ENDORSEMENTS \_\_\_\_\_

TRAFFIC CITATIONS  
LAST 3 YEARS \_\_\_\_\_

## MEDICAL AND EMERGENCY

IN CASE OF  
EMERGENCY NOTIFY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

BLOOD TYPE \_\_\_\_\_ ALLERGIES OR CONDITIONS THAT COULD AFFECT TREATMENT \_\_\_\_\_

PHYSICAL RESTRICTIONS, DISABILITIES, OR LIMITATIONS (INCLUDING, BUT NOT LIMITED TO VISION, HEARING, ALLERGIES, BACK PROBLEMS, LIFTING ABILITY, FEAR OF HEIGHTS, ETC.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12132011@1334

**EDUCATION**

**HIGH SCHOOL**

GRADUATE  YES  NO  GED

**COLLEGE**

(HIGHEST LEVEL COMPLETED)  1  2  3  4

MAJOR AREAS OF STUDY \_\_\_\_\_

**PRESENT EMPLOYMENT**

CURRENTLY EMPLOYED?  YES  NO

IF SO, MAY WE CONTACT YOUR PRESENT EMPLOYER?  YES  NO

NAME OF EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

EMPLOYMENT DATE \_\_\_\_\_

JOB TITLE \_\_\_\_\_

**EMPLOYMENT HISTORY**

ON AN ADDITIONAL PAGE LIST THE LAST 2 EMPLOYERS, BEGINNING WITH THE MOST RECENT ONE . PLEASE INCLUDE: NAME/ADDRESS/PHONE NUMBER OF EMPLOYER, STARTING DATE, ENDING DATE, AND JOB TITLE.

**FIREFIGHTER HISTORY**

PLEASE PROVIDE PROOF OF ALL RELIVANT TRAINING, QUIFICATIONS, AND WORK EXPERIENCE (COPIES MUST BE LEGIBLE).

BE SURE TO INCLUDE A COPY OF YOUR CURRENT FIRST AID/CPR/AED CARD.

**REFERENCES: LIST AND ATTACH THREE LETTERS OF REFFERENCE**

LIST THE NAME OF 3 PEOPLE NOT RELATED TO YOU WHO HAVE KNOWN YOU AT LEAST ONE YEAR: (IF THESE ARE THE SAME REFERENCES AS THOSE LISTED ON YOUR RESUME, SAY "SEE RESUME")

NAME:

ADDRESS:

BUSINESS:

YEARS KNOWN:

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A FELONY CRIME? IF SO, PLEASE EXPLAIN BELOW.  YES  NO

**AUTHORIZATION**

I HEREBY CERTIFY THAT THE ANSWERS GIVEN IN THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION ALONG WITH THE REFERENCES

AND EMPLOYERS LISTED TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PRETINET INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE AND RELEASE THE COMPANY FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM UTILIZATION OF SUCH INFORMATION.

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_