BELLPORT FIRE DEPARTMENT
ORGANIZED 1893
BELLPORT, NEW YORK 11713
MEETINGS: EVERY FIRST MONDAY
PHONE (631) 286-0273, FAX (631) 286-0426

JASON CRANE - Chief
LANCE MACIOCE - 1st Asst. Chief
GILBERTO SANTANA- 2nd Asst. Chief

STEVE MONTICK, Secretary
DAN POLNER, Treasurer

Dear Prospective Member,

This packet contains the instructions and forms you will need to help you initiate the membership process for the Bellport Fire Department. These initial procedures help both you and the department make the first steps towards membership. The Bellport Fire Department has a long tradition of outstanding community service and we are delighted that you have stepped forward to volunteer.

Here are the steps that need to be taken before you become a member of the Bellport Fire Department:

1. You must complete the enclosed membership application, the authorization for records release and the Hepatitis f3 vaccination consent form, (the vaccination is not mandatory; however, we recommend that you do get the vaccination). Please return the completed and signed forms to the fire house, along with a five dollar initiation fee. If you are a minor you will need parental approval. If you are a transfer from another department you must also include a letter from the chief of your previous department summarizing your past performance. The five dollar initiation fee is waived for all transfer applicants.

2. The department secretary will contact you to schedule an interview with the Company captains. (Membership Committee)

3. During the interview you will be given the opportunity to schedule a physical. You must be found fit for duty for the membership process to continue.

4. After the interview and physical the department members will vote on your membership.

5. The completed forms and results of the vote by the membership are then forwarded to the District for their approval.

6. If the District approves your membership you will receive an official letter of membership and congratulations from the Bellport Fire District.

7. The Probationary Training Officer will contact you and initiate your training in the basics of Fire Fighting.

Good luck and Thank you for having the desire and dedication to join the Bellport Fire Department and help your community.

Application for Membership

BELLPORT FIRE DEPARTMENT Date .....

I, ... Date of Birth..... do hereby make

application to become a member of the Bellport Fire Department. My occupation is:.....

I have resided at....., in the Bellport Fire District

For..... (months) (years). Phone Number.....

Social Security No.....

1. Have you ever been a member of a fire department'? Yes .....No .....
2. Are you a citizen of the USA'? Yes.....No .....
3. Have you ever been convicted of a felony'? Yes.....No .....
4. Physical Defects, if any, specify .....
   .....
5. I am a transfer from the .....Fire Dept. & (have - Have not) submitted a letter of transfer with this application. Were you a member in good standing when you left? Yes .....No ..... Reason for leaving previous dept.'? .....
6. Do you have an Exempt firemen's Certificate'? Yes .....No .....
7. Do you have a NY State or Suffolk County fire school certificate? Yes.....No .....
8. My beneficiary is .....Relationship .....Address of beneficiary .....
9. Name and address of next of kin .....

Signature of Applicant .....

If under 21 years of age, application must be accompanied with the written consent of parent or guardian and must be notarized by a Notary Public.

We the undersigned members in good standing in the Bellport Fire Department, do hereby recommend the above-named applicant for membership in the Bellport Fire Department.

1 .....

2 .....

3 .....

An applicant for membership must be a resident of the Bellport Fire District. $5.00 to cover application fee must accompany this application.
Qualifications approved or rejected by the Membership Committee. Approved.....Rejected .....
Reason for rejection .....

Application (approved) (rejected) by the Bellport Fire Department.

Date .....***Signature of Secretary*** .....

Application (approved) (rejected) by Board of Fire Commissioners.

Date .....***Signature of Secretary*** .....

FOR OUR DEPARTMENT RECORDS,
PLEASE FILL OUT THE FOLLOWING INFORMATION

NAME: LAST_____

FIRST_____

MIDDLE_____

DATE OF BIRTH: _____ **SOC SEC #** ____ ____ ____

ADDRESS:

STREET_____

TOWN_____

STATE _____

ZIP CODE_____

HOME# _____ **BUS. #** _____

EMAIL _____

IN EMERGENCY CALL: _____

BENEFICIARY: _____

RELATION: _____

COAT SIZE: _____

BOOT SIZE: _____

ARMED FORCES: YES ❑ NO ❑ BRANCH: _____

BLOOD TYPE:

_____

BLOOD DONOR: YES ❑ NO ❑

BELLPORT FIRE DEPARTMENT

ORGANIZED 1893
BELLPORT, NEW YORK 11713
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DATE _____

I hereby authorize the Suffolk County Police Department to perform an arrest records check, including sealed records if any, and I authorize the release of this information directly to the above named fire department.

_____
NAME

ADDRESS_____

D.O.B._____ S.S.#_____

SIGNATURE _____

SWORN TO BEFORE ME THIS
DATE_____

_____
NOTARY PUBLIC

CONSENT FORM
HEPATITIS B VACCINATION

BOARD OF FIRE COMMISSIONERS Bellport Fire District, Bellport, New York

Firefighters Name:_____

Address: _____

(A) I wish to be included in the Vaccination Program at this time.

_____ _____
Signature Date

OR

I understand that due to my occupational exposures to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposures to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the Vaccination series at no charge to me.

(B) I do not wish to be included in the Vaccination Program at this time.

_____ _____
Signature Date

1st shot: _____ Return Date: _____

2nd shot: _____ Return Date: _____

3rd shot: _____

Arch
Insurance Group®

Arch Insurance Company **Beneficiary Designation Form**

Use this form to designate a beneficiary(ies) for your Accidental Loss of Life Benefit Amount. See page 2 for important information on choosing beneficiary(ies). Complete a new form if you want to designate a new or additional beneficiary(ies).

Policyholder Name and Address

Name _____

Address _____

Insured Information

Insured Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Daytime Telephone Number _____

Beneficiary Information

I am: (Please check appropriate box.)

☐ Designating a beneficiary(ies) for the first time ☐ Changing a previous designation

Primary Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Contingent Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Authorization

For the beneficiary designation(s) I have indicated, I understand that if one of my primary beneficiaries is not living when the benefit is paid, the amount will be divided equally among any remaining beneficiaries. I also understand that no amount will be paid to a contingent beneficiary as long as at least one of my primary beneficiaries is living. I understand that I must complete a new Beneficiary Designation Form if I want to change or revoke my beneficiary designation.

Insured Signature _____ Date _____

Please make a copy of this form for your records and return the original.

(over)

Authorization

Designate a primary and contingent beneficiary for insurance coverage. Refer to the sample wording below for guidance. A contingent beneficiary receives payment in the event the primary beneficiary dies before you do. If you want more than one person to be your beneficiary, please indicate the percentage of the benefit each one should receive (must add up to 100%). If a beneficiary dies before you, his or her benefits will be shared equally among any remaining beneficiaries. Attach a separate signed and dated sheet of paper if you need more space. If you have a change in your family status (such as marriage; divorce; or the birth of a child), you may want to update your beneficiary designations.

Sample Beneficiary Designations

Type of Beneficiary	**Sample Wording**
One beneficiary.....	Doe, John A.; Birthdate; SSN; Husband; 100%
Two beneficiaries.....	Doe, Mary A.; Birthdate; SSN; Mother; 50% Doe, Rich B.; Birthdate; SSN; Father; 50%
Two beneficiaries in unequal shares.....	Doe, Amy J.; Birthdate; SSN; Mother; 75% Doe, Mark F.; Birthdate; SSN; Father; 25%
Three or more beneficiaries in unequal shares.....	Doe, Paul A.; Birthdate; SSN; Father; 75% Doe, James B.; Birthdate; SSN; Brother; 25% Doe, Jaclyn C.; Birthdate; SSN; Sister; 25%
Mark Doe, trustee under trust agreement; Jane Doe Revocable Trust; xxx Main Street; Any Town, State 00000; Dated Month day, year; and amendments or supplements thereto. Any payment to the trustee shall discharge the Plan from any and all liability to the extent of such payment.	

If your beneficiary designations do not fit within the tables on the front of this form, feel free to write the appropriate designation(s) on a separate sheet of paper. Sign and date the separate sheet and attach it to this form.

- All beneficiary designations **must be legible and written in ink.**
- The beneficiary's name must always be shown in full (Last; First; MI), and the relationship to you must be stated.
- If the designated beneficiary is not related to you, the relationship should be "friend."
- The beneficiary section should never contain corrections or crossed-out words.
- The beneficiary designation should be specific. It should not include wording such as "either/or" ; and/or."
- Your right to designate a beneficiary is subject to applicable state law.

Note: For specific legal implications regarding beneficiary designations, contact your attorney.

Designation of Beneficiary Form

For Group Insurance Policies

In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability.

THE HARTFORD

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please ensure your beneficiary designation is clear so there is no question of your intent. **3)** Please sign and date the form. **4)** Submit the form as instructed by your benefits administrator.

EMPLOYER/POLICYHOLDER INFORMATION (Required fields are marked with an asterisk(*)).

*Employer/Policyholder Name	*Policy Number

EMPLOYEE/MEMBER INFORMATION (Required fields are marked with an asterisk(*)).

*Employee/Member Name (First MI Last)	*SSN or Tax ID #	*Date of Birth
*Address (Street, City, State & Zip)	*Marital Status	*Gender
E-mail Address	Phone Number	Cell/Mobile Number

BENEFICIARY DESIGNATION (Required fields are marked with an asterisk(*)).

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request.

All information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. **The percentages must total 100% for all Primary Beneficiaries and 100% for all Contingent Beneficiaries.** If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Important Note: Certain states are community property states. If you live in one of these states – AK, AR, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse/partner consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (Primary beneficiaries are first in line to receive benefits if living at the time of your death.)

1) *Name (First MI Last)	*SSN or Tax ID #	*Date of Birth	*Relationship to You	*Percent %
*Address (Street, City, State & Zip)			Phone Number	
2) *Name (First MI Last)	*SSN or Tax ID #	*Date of Birth	*Relationship to You	*Percent %
*Address (Street, City, State & Zip)			Phone Number	

Contingent Beneficiary(ies) (Contingent beneficiaries will receive benefits if no primary beneficiary is alive at the time of your death.)

1) *Name (First MI Last)	*SSN or Tax ID #	*Date of Birth	*Relationship to You	*Percent %
*Address (Street, City, State & Zip)			Phone Number	
2) *Name (First MI Last)	*SSN or Tax ID #	*Date of Birth	*Relationship to You	*Percent %
*Address (Street, City, State & Zip)			Phone Number	

AGREEMENT & SIGNATURE (Required fields are marked with an asterisk(*)).

I understand that this Designation of Beneficiary applies to **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of my death, unless otherwise requested by me in writing. I also understand that this Designation of Beneficiary is subject to change as provided in each applicable group policy.

By signing below, I acknowledge that: 1) I understand and agree to the terms of this form as noted above; and 2) This Designation of Beneficiary is effective as of the date submitted.

*Employee/Member Signature | *Date of Signature

COMMUNITY PROPERTY CONSENT (To be completed by the Employee/Member's spouse/partner, if applicable).

By signing below, I, _____ (insert your full name), do hereby consent to the foregoing beneficiary designation(s).

Spouse/Partner Signature | Date of Signature

The Standard Life Insurance Company of New York

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
448491			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Bellport Fire District**	Hours Worked Per Week		

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Life Insurance

☑ Basic Life with AD&D (Employer Paid)

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*
Contingent — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*

*Total must equal 100%

Your Full Name

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

FRAUD NOTICE (Only applies to Accident and Health Insurance (AD&D/Disability/Dental))
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Applicant (Member/Employee)	Date

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

firefly ADMIN INC

Bellport Fire District

Length of Service Award Program (LOSAP) — BENEFICIARY DESIGNATION FORM

The purpose of this form is to name the individual(s) you wish to receive any death benefit that may be payable from the LOSAP. New York State Law stipulates that if no beneficiary is named, or if you outlive all your beneficiaries, any death benefit must be paid to your estate. Completing this form does not guarantee that a death benefit will be payable.

This form will supersede any previous designation on file. Before naming your estate or a minor child as a beneficiary, it is strongly suggested that you seek legal advice. Death benefits cannot be paid directly to a minor child.

Please ***print clearly*** using only blue or black ink (not pencil or any other color) and ***keep a copy for your records***. Provide all information requested for each beneficiary; however, SSN is optional for beneficiaries.

YOUR BASIC INFORMATION

Circle One:	Name	SSN	Birthdate
Initial Designation	Mailing Address	Phone	
Change in Designation		Email	

PRIMARY BENEFICIARIES The following Primary Beneficiary(ies) will receive any LOSAP death benefit payable. The total death benefit will be allocated to each Primary Beneficiary based on the *Share Percentage* indicated below. If the total of all Primary Beneficiary Share Percentages is not 100%, this form is not valid. If a Primary Beneficiary dies before you, surviving Primary Beneficiaries will be paid proportionally to their Share Percentage.

Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	

Total 100% *If you wish to name more than two Primary Beneficiaries, please attach a signed addendum.*

CONTINGENT BENEFICIARIES If your Primary Beneficiary(ies) die before you, the following Contingent Beneficiaries will receive any LOSAP death benefit payable. If the total of all Contingent Beneficiary Share Percentages is not 100%, this form is not valid. If a Contingent Beneficiary dies before you, surviving Contingent Beneficiaries will be paid proportionally to their Share Percentage.

Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	

Total 100% *If you wish to name more than three Contingent Beneficiaries, please attach a signed addendum.*

SIGNATURE

This form must be signed and dated to be valid: _____ (Signature) _____ (Date)

firefly ADMIN INC

Bellport Fire District
Length of Service Award Program (LOSAP) ENTITLEMENT FORM

Please complete and return this form along with your age verification (see #2) and bank account verification (see #3) to the Sponsor or to Firefly Admin Inc., 4 Vly Road, Albany, NY 12205. Please keep a copy for your records. You can securely send the form at: www.fireflyadmin.com/securefileupload

1. Participant Information

Name: _____ SSN: _____

Mailing Address: _____

_____

E-mail: _____ Phone: _____

2. Age Verification

To verify your age, you must include a photocopy or screenshot of your driver license, birth certificate, or passport. Please enter your birthdate, then indicate which document is being attached to this form:

Birthdate: _____ ☐ driver license ☐ birth certificate ☐ passport

3. Direct Deposit Election

Direct deposit is optional but strongly encouraged. Firefly and the Sponsor are not responsible for the transmittal of paper checks through the US Mail. Direct deposit is the most secure and timely way to receive your payment. Please provide all the following information and attach your account verification:

Bank Name: _____ Account Type: ☐ Checking ☐ Savings

9-Digit Routing Number: _____ Account Number: _____

Account Verification Attached: ☐ Voided Check ☐ Bank Letter ☐ Other

A voided check must have your preprinted name. A bank letter must be on bank letterhead and include your name, routing number, account number and account type. Other types of verification could be a screenshot of your online account showing the account number and your name, or a direct deposit form from your bank.

4. Tax Withholding Election

Distributions will be subject to federal and possibly state income tax (check with your state tax department), but not FICA taxes or other "payroll" taxes. You will receive a 1099-MISC reporting this income in Box 3 – Other Income. Even if you elect not to have federal and/or state income tax withheld, you are liable for applicable federal and state income taxes. You should consult your tax advisor before making an election. Your tax withholding election will remain in effect until you change or revoke it in writing. A blank line will be interpreted as 0% withholding for that line. State withholding will be for the State of your mailing address noted above unless otherwise indicated.

I elect Federal income tax withholding at a rate of _____%. *This percentage cannot exceed 24%.*

I elect State income tax withholding at a rate of _____%.
We encourage New York State residents to visit www.fireflyadmin.com/nystax/ *before making an election.*

5. Acknowledgement

I hereby certify that: (1) the information I provided is true and accurate; (2) no tax or legal advice has been given to me by either the Sponsor or Firefly Admin Inc.; and (3) I accept the responsibility to seek my own tax and legal advice.

_____ _____
Participant signature Date

NEW YORK STATE DIVISION OF CRIMINAL JUSTICE SERVICES
Office of Criminal Justice Operations
Volunteer Firefighter Inquiry Form

INSTRUCTIONS: This form is to be used only by a Sheriff's Office (or OFPC, where applicable) when performing searches authorized under NY Executive Law §837-o in connection with individuals seeking membership in a Volunteer Fire Department.

This form must be U.S. mailed, faxed or hand delivered between agencies. E-mail transmission is not permissible.

Shaded boxes are required data elements.

A. DATE:

B. REQUESTING VOLUNTEER FIRE DEPARTMENT

DEPARTMENT NAME: Bellport Fire Department

FIRE CHIEF NAME: Jason Crane SIGNATURE:

ADDRESS: 161 South Country Road
Bellport, New York 11713

TELEPHONE NUMBER: (631) 286-0273 FAX NUMBER: (631) 286-0426

1. NAME (LAST, FIRST, MIDDLE)	2. ADDRESS (Street, City, Zip Code)	
3. ALIAS AND/OR MAIDEN NAME	4. SEX M ☐ F ☐	5. RACIAL APPEARANCE White ☐ Black ☐ Indian ☐ Asian ☐ Unknown ☐ Other ☐

6. ETHNICITY Hispanic ☐ Not Hispanic ☐ Unknown ☐	7. HEIGHT Ft. In.	8. DATE OF BIRTH Month Day Year	9. PLACE OF BIRTH

10. SOCIAL SECURITY NO.

RESULTS OF INQUIRY

INVESTIGATING OFFICER: _____ DATE _____
(PRINT NAME/TITLE)

INVESTIGATING OFFICER SIGNATURE _____

☐ NO RECORD OF AN ARSON CONVICTION OR A CONVICTION REQUIRING REGISTRATION AS A SEX OFFENDER

☐ CONVICTED OF ARSON; NO RECORD OF A CONVICTION REQUIRING REGISTRATION AS A SEX OFFENDER

☐ CONVICTED OF A CRIME REQUIRING REGISTRATION AS A SEX OFFENDER; NO RECORD OF AN ARSON CONVICTION

☐ CONVICTED OF ARSON AND CONVICTED OF A CRIME REQUIRING REGISTRATION AS A SEX OFFENDER

Non-Fingerprint Background Checks – Volunteer Firefighters

Effective December 2, 2014, Executive Law §837-o requires prospective volunteer firefighters, and current volunteers seeking membership in another fire company, to undergo non-fingerprint criminal history background checks, **for arson convictions and convictions which require registration as a sex offender only**, against the State's criminal history files maintained by the Division of Criminal Justice Services (DCJS). The law prohibits a fee from being charged in connection with these background checks. The law also specifies that these checks will be conducted by sheriffs' offices unless a county legislature enacts a local law prohibiting its county sheriff from having such responsibility. In such a case, the NYS Division of Homeland Security and Emergency Services, Office of Fire Prevention and Control (OFPC), is authorized to perform the background checks for the affected volunteer fire companies.

DCJS supplies the *DCJS-VFF Volunteer Firefighter Inquiry Form* to each Sheriff's Office in the State and to OFPC. Sheriffs' offices and OFPC shall distribute the form to volunteer fire companies seeking to perform arson and registerable sex offense background checks on prospective volunteers and fire company transferees. Fire company officials should complete sections A and B and fields 1 through 10 of the *DCJS –VFF Volunteer Firefighter Inquiry Form*. Fire company officials should use the applicant/transferee driver's license, and another form of identification, such as a birth certificate, passport or social security card, when completing the forms. Completed forms must be returned to the sheriff's office, or to OFPC where applicable, via U.S. mail, fax or hand delivery. **E-mail transmission is not permissible.** It is not an option to perform the background checks through OFPC in counties where there is no local law prohibiting the sheriff's office from conducting the checks.

Upon receiving a completed *DCJS-VFF Volunteer Firefighter Inquiry Form,* sheriffs' offices will perform a name search on each applicant/transferee using the Criminal Repository Search link located under the People tab in the eJusticeNY Integrated Justice Portal using the VFF Reason Code. If a name search candidate is returned as an exact match to the input data, the sheriff will use the Criminal Repository Inquiry link to obtain a rapsheet from DCJS on the candidate. The rapsheet will then be examined by the sheriff's office to determine the presence of an arson and/or registerable sex offense conviction. Not all sex offense convictions require registration as a sex offender. If there is any question regarding whether the applicant is a registered sex offender, the sheriff should search the Sex Offender Registry using the Full Registry Search link also located under the People tab in the eJusticeNY Integrated Justice Portal. The appropriate box should be checked on the bottom portion of the *DCJS-VFF Volunteer Firefighter Inquiry Form,* and the form returned to the submitting fire company via U.S. mail, fax or hand delivery only. In cases where the rapsheet shows an arrest for arson and/or registerable sex offense, but does not reflect a final disposition for the arrest, the sheriff's office should contact the DCJS Office of Criminal Justice Operations at (518) 457-8547 for assistance in obtaining the final disposition. If an arson and/or registerable sex offense case is pending adjudication, the requesting fire company should be informed that a decision regarding the applicant/transferee must be delayed. **Criminal history records (i.e., rapsheets) are not to be provided to fire companies under any circumstance.**

In cases where a background check results in the discovery of an arson and/or registerable sex offense conviction against an applicant/transferee and the individual disputes the conviction, the fire company official should immediately refer the individual to DCJS for a personal record review. If the personal record review results in the determination that the individual is free of an arson conviction and/or registerable sex offense conviction, a subsequent notification will be sent to the sheriff's office which will then forward the appropriate notification to the fire company. It should be noted that while an applicant/transferee who has been convicted of arson is not eligible to be elected or appointed as a volunteer member of a fire company, a registered sex offender is not automatically disqualified from membership. If the background check results in the discovery that the applicant/transferee is a registered sex offender, the fire company must make a determination of eligibility in accordance with the criteria established in Correction Law §§752 and 753. The fire company should be directed to contact the Sex Offender Registry at 1-800-262-3257 to obtain more information about the conviction.

PERMISSION SLIP

To the Bellport Fire Department:

I understand that my child is applying for membership in the Bellport Fire Department as an active member and that, inasmuch as he/she is below the age of 18 years, my permission is required as part of the application process.

I have read the following information concerning active membership in the Bellport Fire Department and I understand same. With full knowledge of the conditions as explained below I consent to permit my child,

_____

(Print Name of Child)

to join the Bellport Fire Department.

I understand that active members:

1. Are required to make a certain percentage of calls.
2. Are required to participate in a certain amount of training.
3. Are provided with safety training and equipment.
4. Are covered by insurance in case of injury.
5. May be subjected to fire, smoke, and other hazardous situations.

I further understand that members who are still in high school may not participate in any department activities while school is in session.

Dated: _____

_____

Parent or Legal Guardian Signature
(please print name below)

_____