

## New Jersey State Firemen's Association

**THIS NOTICE IS FOR YOUR INFORMATION. YOUR SIGNATURE IS REQUIRED.**

**Privacy Notice for our (Potential) Members.**

**Please review it carefully.**

The New Jersey State Firemen's Association (NJSFA) and each officer and the office staff and all the local associations through out the state strongly believe in protecting the confidentiality and security of the information we receive about you. This notice refers separately to the New Jersey State Firemen's Association and each of the local associations by using the terms "us", "we", or "our". This notice describes our privacy policy and describes how we treat the information we receive about you.

**Why We Receive and How We Use Information:** We receive the initial information via a Membership Application and Physical Test Record, Form # 100. The purpose of this application is to permit membership in our organization. This information is used to make sure the applicant is in compliance with New Jersey State Statutes and our Compendium and by-laws.

**How We Receive Information:** We get most information from you. The Secretary of the local Relief Association forwards the application form to our office. The information that you give us when applying for membership generally provides the information we need. If we need to verify information or need additional information, we may obtain information from third parties such as physicians, hospitals and other medical personnel. Information collected may relate to your health or other information stated on the application.

**How We Protect Information:** We treat information in a confidential manner. Our Officers, Advisory Committee and Office Staff are required to protect the confidentiality of information. We access information only when there is an appropriate reason to do so. We also have safeguards to protect information. All Officers, Advisory Committee and Office Staff are required to comply with our policies.

**Information Disclosure:** We may disclose any information when we believe it necessary for the operation of our association, or where disclosure, is required by law. The application if in question may be forwarded to our Association Medical Doctor for evaluation. We do not make any other disclosures of information to other organization or companies who may want to sell their products or services to you. We will not sell your name or application information to any organization, corporation or catalog company.

**Access to and Correction of Information:** Generally, upon written request, we will make available your personal information for your review. Information received in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. This will be included under "disclosure of information".

**PLEASE RETAIN - DO NOT RETURN TO YOUR LOCAL ASSOCIATION  
OR TO THE STATE OFFICE.**

# N. J. STATE FIREMEN'S ASSOCIATION

## PHYSICAL EXAMINATION GUIDELINES

### VALID FOR 180 DAYS

1. AGE: Must be at least 18 years of age and not older than 45 years of age.
2. EYES: Must be 20/30 corrected ( with glasses, contacts, or surgical procedures).
3. HEARING: Loss of hearing acuity so as to be unable to perceive sounds within normal voice range with or without hearing aid.
4. NOSE: Any significant nasal obstruction to free breathing not subject to correction by surgery.
5. MOUTH: Conditions which impair ability to communicate.
6. NECK: Problems resulting from (a) Goiter; (b) Limited range of motion; which prohibits turning, extension or free movement of the 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.
7. PULMONARY: Problems resulting from loss or removal of a 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.
8. CARDIO PULMONARY SYSTEM: Problems resulting from Heart disease or cardiomegaly.
9. PERIPHERAL VASCULAR SYSTEM: Problems resulting from (a) Varicose veins; (b) Aneurysms; (c) Lymphedema; (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 than 150 but not lower than 90. Diastolic Maximum should be 100 mmhg, Minimum 50 mmhg.
10. ABDOMEN: Problems resulting from (a) Organomegaly; (b) Signs of tenderness in an area; (c) Presence of masses such as hernias of various types.
11. 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.
12. 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.
13. OTHERS: Problems arising from (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 fireperson.

**THESE MEDICAL GUIDELINES ARE TO BE FOLLOWED BY A PHYSICIAN LICENSED IN THE STATE OF NEW JERSEY WHEN EXAMINING AN APPLICANT FOR MEMBERSHIP. ANY ABNORMAL FINDINGS MUST BE EXPLAINED IN THE REMARKS SECTION OF THE APPLICATION. ALL SECTIONS OF THE PHYSICAL MUST BE PROPERLY FILLED OUT OR THE APPLICATION WILL BE RETURNED.**

ASSOC. NO.	COMP. NO.	LINE NO.
FOR STATE OFFICE USE ONLY		

**N.J. STATE FIREMEN'S  
ASSOCIATION  
MEMBERSHIP APPLICATION**

Form 100 – Rev. 9/17

Date \_\_\_\_\_

Relief Association \_\_\_\_\_ Municipality \_\_\_\_\_ County \_\_\_\_\_

Department \_\_\_\_\_  
Company \_\_\_\_\_

Name \_\_\_\_\_  
First Initial Last

Street Address \_\_\_\_\_ Town \_\_\_\_\_ Zip Code \_\_\_\_\_ For \_\_\_\_\_ Years

Birth date \_\_\_\_\_ Birthplace \_\_\_\_\_ SS# \_\_\_\_\_  
**(REQUIRED)**

Have you ever applied to be a member of the New Jersey State Firemen's Assoc.?  Yes  No

If so, when \_\_\_\_\_ Where \_\_\_\_\_

The signature below certifies that I have received and read the attached PRIVACY NOTICE.

Phone No. \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Applicants Email Address: \_\_\_\_\_

I hereby authorize the State Association to move my records to the above Association/Company.  
\_\_\_\_\_  
Signature of Applicant **(FILL-IN ONLY IF APPLICABLE)**

\_\_\_\_\_  
SIGNATURE OF RELIEF ASSOCIATION SECRETARY

\_\_\_\_\_  
SIGNATURE OF CHIEF OF DEPARTMENT

**STATE OF NEW JERSEY COUNTY OF** \_\_\_\_\_

\_\_\_\_\_  
Applicant's Name Being duly sworn, doth depose and says that the above statements are true to the best of their knowledge and belief. Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Seal \_\_\_\_\_ Expiration Date \_\_\_\_\_ SIGNATURE OF NOTARY PUBLIC \_\_\_\_\_

**MUNICIPAL APPROVAL**

We hereby certify that this applicant was admitted to active membership in the department and has been approved by the governing body of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF MUNICIPAL CLERK/ BOARD OF FIRE COMMISSIONERS

**IMPORTANT: APPLICATION MUST BE FILLED OUT AS INDICATED BELOW**

- A. APPLICATION SHOULD BE COMPLETED BY APPLICANT, TYPED OR PRINTED. **(DO NOT WRITE)**
  - B. APPLICANT MUST HAVE PHYSICAL TEST RECORD COMPLETED BY A LICENSED NEW JERSEY PHYSICIAN.
  - C. APPLICATION MUST BE RETURNED TO THE LOCAL RELIEF SECRETARY WHOSE ADDRESS IS LISTED ON THE BACK PAGE OF THIS FORM.
  - D. THE LOCAL RELIEF SECRETARY SHALL COMPLETE THE FORM AND FORWARD IT TO THE MUNICIPAL AUTHORITY FOR APPROVAL, THEN TO THE NEW JERSEY STATE FIREMEN'S ASSOCIATION.
- THE APPLICANT IS NOT A MEMBER OF THE N.J.S.F.A. UNTIL THE COMPLETED ORIGINAL APPLICATION IS RECEIVED AND APPROVED AT THE NEW JERSEY STATE FIREMEN'S ASSOCIATION OFFICE.**

# PHYSICAL TEST RECORD (VALID FOR 180 DAYS)

TO BE FILLED OUT BY A PHYSICIAN LICENSED IN THE STATE OF N.J. AND RETURNED TO LOCAL RELIEF SECRETARY WHOSE ADDRESS IS 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 \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_  
(NUMBERS PLEASE)  
EYESIGHT LEFT \_\_\_\_\_ RIGHT \_\_\_\_\_ BOTH (CORRECTED) \_\_\_\_\_  
(NUMBERS PLEASE)

HAS APPLICANT ANY APPARENT DISABILITIES IN:

FACIAL \_\_\_\_\_ PULMONARY \_\_\_\_\_  
CARDIO PULMONARY \_\_\_\_\_ VASCULAR \_\_\_\_\_  
ABDOMEN \_\_\_\_\_ GENITOURINARY \_\_\_\_\_  
MUSCULO-SKELETAL \_\_\_\_\_ OTHER \_\_\_\_\_

The applicant is free of any other, than listed above, medical or physical conditions that would cause harm to him/her or any other firefighter(s). YES  No  (If no please explain)

HAS APPLICANT EVER SUFFERED FROM INJURY?  YES  NO IF SO, WHEN? \_\_\_\_\_  
DESCRIBE \_\_\_\_\_  
\_\_\_\_\_

REMARKS/OR REJECTION IS BASED ON:

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

DATE EXAMINED \_\_\_\_\_ EXAMINED AT \_\_\_\_\_ ADDRESS OF OFFICE \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER \_\_\_\_\_ PRINT PHYSICIAN'S NAME \_\_\_\_\_ SIGNATURE OF PHYSICIAN \_\_\_\_\_

**VALID FOR 180 DAYS FROM DATE OF PHYSICAL**

THE NEW JERSEY STATE FIREMEN'S ASSOCIATION RESERVES THE RIGHT TO HAVE THIS APPLICATION REVIEWED BY A MEDICAL DOCTOR OF ITS CHOICE, INCLUDING A NEW PHYSICAL EXAMINATION IF NECESSARY.

APPLICATION MUST BE RETURNED TO: \_\_\_\_\_ LOCAL RELIEF SECRETARY \_\_\_\_\_  
NAME ADDRESS ZIP CODE