PICTURE ROCKS FIRE AND MEDICAL DISTRICT
EXPLORER PROGRAM
APPLICATION PACKET CHECKLIST

Applications can be dropped off in person at to the Unit Post Advisor at Station 121.

APPLICANT'S NAME: ____

DATE: _____________________

CHECKLIST:

- ☐ Learning for Life Application
- ☐ Membership Dues Check* *May bring to first Explorer Meeting attended after acceptance into the program*
- ☐ PRFMD Explorer Membership Application (2 pages)
- ☐ Explorer Information Sheet
- ☐ Certificate of Program Eligibility Form
- ☐ Confidential Scholastic Inquiry
- ☐ Medical Examination Report & Health Questionnaire (2 pages)
- ☐ Medical Examination Report (completed by physician)
- ☐ Insurance Authorization Form
- ☐ PRFMD Authorization to Consent to Treatment of a Minor
- ☐ Waiver/Release of Liability
- ☐ Copy of Recent Grade Report

I have reviewed this Explorer Application Packet and verify that it is complete.

____

Signature of Post Advisor or Associate Advisor

Remarks:

____

____

____

____

This form is read by machine. Please print the numbers and letters as shown on the sample application.

YOUTH PARTICIPANT

Post number:

If applicant has an unexpired participant certificate, participation may be accomplished in this unit by paying $1 for processing the transfer. Mark and attach certificate. It will be returned by the council.

○ Transfer application   Transfer from council number: Post number:

E-mail:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)**   Middle name   Last name   Suffix

Country US   Mailing address   City   State   Zip code

Home phone - -   Date of birth (mm/dd/yyyy) / /   Grade

Ethnic background:
○ African American ○ Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School

Gender: ○ Male ○ Female

LOCAL COUNCIL COPY

Parent/guardian information   ○ Mark here if address is same as above.

○ Mark here if the adult parent/guardian is not living at the same address; complete and attach a Learning for Life adult application.

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)**   Middle name   Last name   Suffix

Country US   Mailing address   City   State   Zip code

Home phone - -   Date of birth (mm/dd/yyyy) / /   Occupation   Employer   Gender: ○ M ○ F

Business phone - - X   Ext.   Previous Exploring experience   Cell phone - -

Parent/guardian e-mail address

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of post leader   Date / /

Signature of parent/guardian

6001   Registration fee $.

Signature of Explorer

28-309

Retain on file for three years.

PICTURE ROCKS FIRE & MEDICAL DIST EXPLORER PROGRAM

Post # ___________

MEMBERSHIP APPLICATION

INSTRUCTIONS: All answers are to typewritten or printed legibly in ink. **Each question on this form must be answered, leaving no blanks**. If the question does not apply, enter "DNA" in the space provided for the answer. Any false statement made on this application will cause the applicant's name to be removed from the eligible list or be cause for immediate dismissal if an appointment is made.

PERSONAL INFORMATION

Full Name:

Aliases or Nicknames:

Residence Address: (Number & Street) (City) (Zip code) **Phone Number:**

Mailing Address: (Number & Street) (City) (Zip code)

Date of Birth: **Place of Birth:** City County State **Social Security #:**

If a Naturalized Citizen, list the City, County, and State where Naturalized:

Sex: **Age:** **Height:** **Weight:** **Hair:** **Eyes:** **Build:** Light ☐ Medium ☐ Heavy ☐

I live with: **Father** ☐ **Mother** ☐ **Stepfather** ☐ **Stepmother** ☐ **Other** ☐

Parent/Guardian Names:

Person to Notify in Event of Emergency: **Phone Number:**

REFERENCE INFORMATION *(List three references other than relatives or past employers)*

Name: **Address:** **Phone Number:**

Employer's Name: **Years Known:**

Name: **Address:** **Phone Number:**

Employer's Name: **Years Known:**

Name: **Address:** **Phone Number:**

Employer's Name: **Years Known:**

SCHOOL INFORMATION

School Name: **Counselor's Name:**

School Address: (Number & Street) (City) (State) (Zip code)

Grade Point Ave.: **Current Grade Level:** **Dates of Attendance:** **to**

Have you ever received a referral or detention from school? Yes ☐ No ☐

Have you attended more than one high school in the past two years? Yes ☐ No ☐

PLEASE ATTACH A **COPY** OF YOUR MOST RECENT GRADE REPORT FROM SCHOOL.

EMPLOYMENT INFORMATION

Employer's Name: **Phone Number:**

Your Job Title: **Number of Hours per Week:**

Briefly describe duties:

TRAFFIC INFORMATION

AZ Driver License #: **Class of License:** **Expiration Date:**

List below every driver's license you have possessed

State	Number	Approximate Issue Date	Approximate Expiration Date

ARREST INFORMATION

Have you ever been detained for investigation, held on suspicion, or arrested by any lawenforcement agency? Yes ☐ No ☐

Have you ever been arrested for any traffic violation? Yes ☐ No ☐

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS 'YES', LIST THE INFORMATION REQUESTED BELOW.

Date	Charge	Arresting Agency	Penalty

REMARKS:

By submitting application to the Picture Rocks Fire & Medical District Explorer Program, we understand that any appointment tendered will be contingent upon the results of a thorough character and fitness investigation conducted by the Picture Rocks Fire & Medical District. This investigation may include, but is not limited to, criminal record checks by computer, contacts with official law enforcement agencies, personal references, employers (past and present), and officials of schools of attendance.

We are aware any false statement made on this application will cause the applicant to be removed from further consideration for membership.

We hereby waive any claim against the Picture Rocks Fire & Medical District, its officers and employees, the Director of Fire Services, and all members of the Picture Rocks Fire & Medical District for pursuing an aggressive and detailed background investigation into the applicant for Fire Explorer. We understand that such investigation shall remain confidential whether or not the applicant is allowed membership as an Picture Rocks Fire & Medical District Explorer.

Date__________________ **Exploring Applicant's Signature** ______________________________

Date__________________ **Parent/Legal Guardian's Signature** ______________________________

Explorer Information Sheet

Participation Date: ____

Name: ____

School Name: ____

Age: ____

Birth Date: ____

Contact Number 1: ____

Contact Number 2: ____

Parent(s) or Guardian Name: ____

____

Parent(s) or Guardian Contact: ____

____

Emergency Contact Name: ____

Emergency Contact Number: ____

Personal Physician Name: ____

Personal Physician Number: ____

____ ____

Student's Signature Parent's Signature

If you have any questions or comments, please contact Post Advisor NAME at NUMBER.

Certificate of Program Eligibility Form

Applicant's Name: ________________________________

Applicant's Date of Birth: ________________________________

School Name: ________________________________

Last Grade Completed: ________________________________

My son/daughter/ward does not have any physical or mental conditions that would limit his/her safe participation in the Picture Rocks Fire and Medical District Fire Explorer Program.

Initials: _______________

Explorer must be 14 years of age and have completed the 8th grade. Explorers shall not be older than 21 years of age. Explorers must have a minimum 2.0 (C) grade point average and a passing in all subjects on their most recent semester report card.

My son/daughter/ward meets these requirements.

Initials: _______________

Please list any special medications, limitations or conditions that you wish the Exploring Post Adult Leadership to be aware of. Please include any allergies or handicaps that your son/daughter/ward has. You may also include any special medical directives to be followed in case of an emergency.

____
____
____
____
____

Please list persons to contact in the event of an emergency:

Name: ______________________________ Phone Number: ______________________________

Name: ______________________________ Phone Number: ______________________________

PICTURE ROCKS
FIRE & MEDICAL DISTRICT

12121 W. PICTURE ROCKS RD | prfmd.org
TUCSON, AZ 85743 | 520.682.7878

To Whom It May Concern:

Subject: **Confidential Scholastic Inquiry**

Name:____

The above person has applied for affiliation with the Picture Rocks Fire and Medical District as a Fire Explorer. Members are required to be of good moral character, honest, industrious and sober.

All Fire Explorer applicants must successfully pass a background evaluation before they can be deemed qualified. This applicant has stated that he/she attended your school from ___________________ to________________.

Please fill out the attached form completely. Your verification of these facts and other information will be treated ***confidentially***. For your convenience, we have enclosed a self-addressed envelope. Your cooperation and prompt return of this inquiry will be greatly appreciated.

Sincerely,

Wes Crary
Explorer
Coordinator

RELEASE

Aspiring to be a member of the Picture Rocks Fire District as a Fire Explorer and desiring them to be informed as to my previous record and character, I hereby authorize the appropriate officials of my elementary, middle, and/or high school to furnish any and all such information which may concern my record. I hereby waive any claim against school officials from any charge because of furnishing said information.

Signature:______________________________________ Date: _________________

Parent/Guardian:________________________________ Date:_________________

PICTURE ROCKS FIRE & MEDICAL DIST EXPLORER PROGRAM

MEDICAL EXAMINATION REPORT & HEALTH QUESTIONNAIRE

Name: ____

Last First M.I.

TO THE APPLICANT: *Medical clearance is required prior to acceptance as a Fire Explorer. As far as it is practical, the Explorer Post, in cooperation with the Post Advisor, will evaluate the medical fitness of each applicant to carry out the duties of the position for which he or she is eligible. It is for this purpose that the following questionnaire is supplied to you. Your cooperation in filling in this questionnaire as completely as*

1. Birthdate:____________________

2. Male ☐ Female ☐

3. Height________Weight________

4. Do you wear glasses? ☐ Reading ☐
   Contact lenses? ☐
   Neither one

5. Are you blind in one eye? ☐
   Both eyes? ☐
   Neither one ☐

Have you ever had, or do you currently have, any of the following? Supply details on ***"yes"*** *answers in space provided at end of questions. If the condition required hospitalization, check the corresponding box.*

		NO	*YES*	*HOSP*			*NO*	*YES*	*HOSP*
6	Tuberculosis or other lung trouble	☐	☐	☐	23	Rupture or hernia	☐	☐	☐
7	After effects of poliomyelitis	☐	☐	☐	24	Gall bladder trouble	☐	☐	☐
8	Hepatitis or jaundice	☐	☐	☐	25	Kidney or bladder trouble	☐	☐	☐
9	Cancer	☐	☐	☐	26	Skin trouble	☐	☐	☐
10	Pernicious anemia, leukemia or other blood disorder	☐	☐	☐	27	Any defect of bones or joints including amputations	☐	☐	☐
11	Asthma	☐	☐	☐	28	Rheumatism or arthritis	☐	☐	☐
12	Diabetes or sugar in urine	☐	☐	☐	29	Back pain or back injury	☐	☐	☐
13	Tumor	☐	☐	☐	30	Head injury	☐	☐	☐
14	Mental illness or nervous breakdown	☐	☐	☐	31	Knee injury	☐	☐	☐
15	Epilepsy or convulsions	☐	☐	☐	32	Fainting spells	☐	☐	☐
16	Any disorder of the nervous system	☐	☐	☐	33	Shortness of breath	☐	☐	☐
17	Severe headaches	☐	☐	☐	34	Any complications from childhood diseases	☐	☐	☐
18	Heart trouble - include circulatory	☐	☐	☐	35	Any eye disease or eye surgery	☐	☐	☐
19	Stomach or duodenal ulcer or other digestive problem	☐	☐	☐	36	Any problem with hearing or require a hearing aid	☐	☐	☐
20	High blood pressure	☐	☐	☐	37	Any speech impairment	☐	☐	☐
21	Varicose veins	☐	☐	☐	38	Addiction to drugs or alcohol	☐	☐	☐
22	Rheumatic fever	☐	☐	☐	39	Any problem with menstruation	☐	☐	☐

PICTURE ROCKS FIRE & MEDICAL DIST EXPLORER PROGRAM

MEDICAL EXAMINATION REPORT & HEALTH QUESTIONNAIRE

(Continued)

40. Have you ever had any operation? If so, date and type of operation:____

____

41. Any other illness, injury or physical condition not named above other than childhood diseases or minor illnesses? If so, what? ____

42. Have you ever had an injury which caused you to lose time from work within the last 5 years? No ☐ Yes ☐

43. Have you ever been released from employment or from the armed forces for medical or health reasons? No ☐ Yes ☐

44. Have you ever received or applied for pension or compensation for disability? No ☐ Yes ☐

45. Are you at present under the doctor's care for any condition? No ☐ Yes ☐

46. Are you taking any medication at this time? No ☐ Yes ☐
If so, what?____

47. Do you consider that there is any limitation on your ability to carry out the duties of the position? No ☐ Yes ☐

Please write your own account and your own evaluation of any items to which you have answered "yes" in the preceding questionnaire. Include, if possible, diagnosis, date of onset, your present condition as you evaluate it, and what limitations, if any, you feel it may impose on your ability to perform satisfactorily the duties of Fire Explorer.

I certify that I have provided true and complete information concerning my health.
(Any misrepresentation or material omission may be cause for dismissal).

Signature:____ Date: ______________________

PICTURE ROCKS FIRE & MEDICAL DISTRICT

EXPLORER PROGRAM

MEDICAL EXAMINATION REPORT

Name:____
Last First M.I.

(To be completed by a licensed physician)

Height:____________________ Weight: ____________________	VITAL SIGNS: Blood Pressure: ____________________ Pulse: ____________________
HEARING: (Ordinary conversation at 20' considered normal) Right___________/20 Left___________/20 Hearing Aid Used: No ☐ Yes ☐	VISION: Uncorrected: Corrected: Right 20/___ Right 20/___ ☐ Glasses Left 20/___ Left 20/___ ☐ Contact Lenses
HEAD: (Eyes, ears, nose, mouth, throat)	LUNGS:
HEART & CIRCULATORY SYSTEM:	NERVOUS SYSTEM:
URINALYSIS: SP. Gravity: Albumin: Sugar:	RECTAL: Fissures? Fistula? Hemorrhoids?
GENITO-URINARY:	ABDOMEN, G-1 TRACT: Hernia?
SPINE:	EXTREMITIES:
SKIN:	VARICOSE VEINS: (Severity)

RECOMMENDATION & COMMENTS:

☐ Fit (no reservations)

☐ Fit for limited work (Please comment on any limitations of type or amount of activity suggested or recommended)

☐ Unfit (Please comment)

SIGNATURE OF EXAMINER:____ DATE: ____________________

PRINTED NAME OF EXAMINER:

ADDRESS:

PHONE:

PICTURE ROCKS FIRE AND MEDICAL DISTRICT EXPLORER PROGRAM
INSURANCE AUTHORIZATION FORM

TO THE APPLICANT: *Be aware that primary, comprehensive medical insurance coverage is your responsibility and not that of the Orange County Fire Authority. Prior to acceptance as an Explorer, consent is required for use of your personal medical insurance plan for any injury or illness that occurs during participation in authorized Exploring Program activities. Limited secondary plans provided through the Boy Scouts of America cover you after exhaustion of your primary plan. Your cooperation in filling out this form as accurately and completely as possible will expedite the use of these policies should the need occur.*

EXPLORER APPLICANT INFORMATION:

POST #:____________________ POST ADVISOR:____

NAME:____
LAST FIRST M.I

ADDRESS:____
STREET P.O. BOX/APT. # CITY ZIP CODE

SOCIAL SECURITY #:____________________________ DOB:________________________

CONTACT IN EMERGENCY:________________________________ PHONE #: ____________________

MEDICAL INSURANCE PRIMARY POLICY INFORMATION:

INSURANCE COMPANY:________________________________ PHONE #: ____________________

ADDRESS: ____
STREET P.O. BOX/APT. # CITY ZIP CODE

POLICY #______________________ GROUP #________________________ PLAN # ____________________

INSURED'S EMPLOYER: ____

EMPLOYER'S ADDRESS: ____
STREET P.O. BOX # CITY ZIP CODE

PHONE #:____________________ EXT:________ INSURED'S SS #: ____________________________

CERTIFICATE OF INSURED (Read Carefully Before Signing): *The undersigned hereby affirms the foregoing information is true and correct and understands any willful misstatement or omission of material facts herein will cause forfeiture to all rights to any activities with the Exploring Program. Further, the undersigned agrees to advise the Post Advisor of any change, cancellation, or revision of policy coverage within 72 hours of said change. This form authorizes billing of the above insurance company by any hospital, medical center, or emergency room that administers medical attention for any injury or illness induced while taking part in any authorized Exploring activities.*

INSURED'S SIGNATURE:____ DATE: ____________

EXPLORING APPLICANT'S SIGNATURE:__________________________________ DATE:____________

PRFMD Authorization to Consent to Treatment of a Minor

(I) (We), the undersigned, parent(s) of ________________________, a minor, do hereby authorize the Fire Chief of the Picture Rocks Fire and Medical District, one of his employees, as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the medical practice act, whether such diagnosis or treatment rendered at the office of said physician or at a hospital, and any special medical directives noted below under "MEDICAL DIRECTIVES" by the undersigned. In the event of any injury whereby medical attention at the scene of the accident is deemed necessary by said agents or paramedics or emergency medical technicians called to the scene, (I) (We) further authorize said agents to consent on (My) (Our) behalf to treatment at said scene by said paramedics or emergency medical technicians. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agents to give specific consent to any and all diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his/her best judgment may deem advisable, as long as the medical directives are abided and followed.

This authorization shall remain effective until ____________________________, unless sooner revoked in writing delivered to said agent(s).

____	____
FATHER	MOTHER
____	____
LEGAL GUARDIAN	WITNESS

PERSONAL HISTORY

Minor's Full Name:

_________________________	______________________	___________	_____ / _____ / _____
Last	First	M.I.	Date of Birth

Personal Physician's Name: ____________________________ Work Phone: ____________________

Medical Directives: ____

Medical Problems:

____

____

____

PICTURE ROCKS
FIRE & MEDICAL DISTRICT
12121 W. PICTURE ROCKS RD., TUCSON, AZ 86743
P: 520.682.7878 F: 520.682.0421 www.picturerocksfire.org

This document is a waiver and release of liability for the Picture Rocks Fire and Medical District (PRFMD), its Board of Directors, its officers, agents, employees, and assigns. The participant will be referred to as an “Explorer”. Explorer is hereby informed, agrees, and understands that the PRFMD Exlplorer Program may result in serious injury, exposure to disease, mental anguish and emotional distress, and property damage and loss. In consideration of participation in the PRFMD Explorer Program Explorer agrees to WAIVE and RELEASE liability of PRFMD, its Board of Directors, its officers, agents, employees, and assigns.

Explorer assumes all risks associated with the Explorer Program including riding in an ambulance and responding to emergency situations. This assumption of risk includes routine activities as well as responding to emergencies and the risks associated with the scene of an emergency.

Explorer hereby WAIVES and RELEASES any and all liability, and agrees to hold PRFMD, its Board of Directors, its officers, agents, employees, and assigns harmless, for any and all death, bodily injury, sickness, illness, disease, contagion, mental anguish and emotional distress, or property damage sustained by Explorer while participating in the PRFMD Explorer Program, on or off PRFMD property, while seated in or situated on any vehicle owned or operated by PRFMD, or while at the scene of any incident to which an PRFMD Ambulance has responded. Explorer further agrees to INDEMNIFY PRFMD for any and all loss, damage, or liability which PRFMD, its officers, employees, and agents may sustain as a consequence of the acts or conduct of Explorer.

In consideration of Explorer’s waiver and release of liability, agreement to hold harmless, and promise to Indemnify, PRFMD agrees to allow Explorer to ride in an PRFMD Ambulance or other emergency vehicle to the scene of emergencies, while in the company of PRFMD employees or agents. Explorer’s participation in the PRFMD Explorer Program is completely in the discretion of PRFMD and PRFMD reserves the right to refuse participation or terminate participation immediately for any reason. The permission granted by PRFMD in this Agreement may be revoked at any time by any employee or agent of PRFMD.

PICTURE ROCKS
FIRE & MEDICAL DISTRICT

12121 W. PICTURE ROCKS RD., TUCSON, AZ 86743
P: 520.682.7878 F: 520.682.0421 www.picturerocksfire.org

THIS WAIVER, RELEASE, AND INDEMNITY IS BINDING ON THE EXPLORER, HIS OR HER HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS.

I have read and understand this Waiver and Release of Liability and Indemnity Agreement. In addition, by signing this document, I represent that I am 18 years of age or older; that I am signing this document of my own free will; and that I am fully aware of the risks inherent in riding in an ambulance.

____
Printed Name of Explorer

____
PRFMD Representative

____
Signature of Explorer

____
Date

____
Date

PARENT OR GUARDIAN AGREEMENT AND CONSENT TO WAIVER AND RELEASE OF LIABILITY AND INDEMNITY AGREEMENT

I, hereby affirm that I am the parent or legal guardian of________________________________, who has signed the foregoing Waiver and Release of Liability and Indemnity Agreement. I agree and consent to the foregoing Waiver and Release of Liability and Indemnity Agreement and I consent to my child or ward to participate in the PRFMD Explorer Program. I further state that I am of lawful age and legally competent to sign this Parental or Guardian Agreement on behalf of my child or ward. I have read and understand both this Agreement and Consent and the Waiver and Release of Liability Agreement signed by my child or ward. By signing this document I agree and understand that my child or ward has waived and released liability, and agreed to indemnify PRFMD, for himself and his heirs and assigns which includes me. I have fully informed myself of the contents of both documents by reading them before I have signed below.

__________________________ Printed Name of Parent or Guardian

__________________________ PRFMD Representative

__________________________ Signature of Parent or Guardian

__________________________ Date

__________________________ Date