

# SOMERVILLE AUXILIARY FIRE DEPARTMENT

## Applicant Health Information Page

If I am accepted into the Somerville Auxiliary Fire Department I understand that as a member of this unit my duties at fire ground operations, emergency scenes, disaster locations or other incidents may require that I operate in an environment which might generate danger. Such environments may involve products of combustion, carbon monoxide, carcinogens, hazardous chemicals and other potentially dangerous materials or conditions.

I also understand that the members of the Somerville Auxiliary Fire Department receive limited medical insurance coverage.

### *APPLICANT ACCEPTANCE*

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### *APPLICANT ACKNOWLEDGEMENT*

I have been examined by a physician and I do not have any medical condition which will endanger my health or hinder or prevent me from performing firefighting duties, fire related duties or other duties and responsibilities relative to services provided by the Somerville Auxiliary Fire Department.

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### *PHYSICIAN APPROVAL*

Name of Primary Care Physician (print): \_\_\_\_\_

Physician/Medical Office Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Signature of Primary  
Care Physician: \_\_\_\_\_

Date \_\_\_\_\_