



Burke Volunteer Fire & Rescue Department
9501 Old Burke Lake Road Burke, Virginia 22015
(703) 978-9200

Dear Prospective Member:

We are pleased you are interested in becoming a member of the Burke Volunteer Fire and Rescue Department [BVFRD]. We are seeking committed individuals who wish to contribute time and talent to the community as an active member of our organization. Before you complete the attached application, however, we urge you to read this letter completely so that you have an understanding of the application process and the level of commitment required.

BVFRD has been a proud part of the Burke community since 1947. We are one of twelve volunteer departments within the Fairfax County Fire and Rescue Department. The Fairfax County Fire and Rescue Department is a combined fire and rescue system with both career and volunteer members with career firefighters covering over 30 fire stations in the county on a 24 hour a day basis.

To be considered an ACTIVE MEMBER of BVFRD and receive member benefits, members must be at least 18 years of age and participate at least 20 hours a month either in administrative functions, training, or riding the apparatus. This includes attending monthly membership meetings [2nd Monday of the month] and monthly training activities [4th Monday of the month]. Additionally, the membership has specified that new members shall not be accepted if they are tobacco product users.

We have two categories of Active Membership: Support and Operational. Support members assist with management of all aspects of the Department, which can include, but is not limited to participation in fundraising, personnel administration, CPR instruction, and/or community relations activities.

There are two types of Operational membership: 1) EMS-Only or 2) Suppression/EMS. The EMS-Only member is one where his/her primary interest is riding the ambulance and providing EMS care and is certified as an Emergency Medical Technician [EMT-B] by the Commonwealth of Virginia. The Suppression/EMS member is interested in riding both the EMS and the fire/rescue apparatus and providing EMS care and firefighting/rescue services and is certified as both a Virginia EMT-B and Firefighter.

Those seeking Operational Membership status are required to pass a Fairfax County medical examination before riding or beginning EMT/Fire training at the Fairfax County Fire and Rescue Training Academy. Providing fire and EMS services is both mentally and physically demanding and requires the individual to be in good physical condition. If you have any medical condition[s] that may compromise your ability to perform as a firefighter or EMT, we suggest you first see your doctor and get his/her opinion as to whether you are physically capable of doing this type of work as we have found that applicants are unable to pass the medical exam due to previous injuries or present medical conditions. If you have specific questions about the criteria for the physical exam, you should call Robert Mizer, the Volunteer Liaison, at 703-246-3926.

**A non-profit corporation providing Fire, Emergency Medical and Rescue services
to the citizens of Burke and Fairfax County**



Burke Volunteer Fire & Rescue Department
9501 Old Burke Lake Road Burke, Virginia 22015
(703) 978-9200

MEMBERSHIP APPLICATION

TYPE OF MEMBERSHIP REQUESTED:

Operational – Fire/Suppression Operational - EMS Only
 Support Personnel Associate

PERSONAL INFORMATION

Social Security Number _____ Date of Birth _____
Last Name _____ First Name _____ M.I. ____ Nickname _____
Address (Street, Apt. No.) _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____
Pager _____ Mobile _____
Email _____
Height _____ Weight _____ Blood Type _____
Hepatitis B Inoculation Date _____
Allergies _____
Birthplace (City, State) _____ Marital Status _____
Emergency Point of Contact (POC) _____ Relationship _____
POC Phone Numbers (Home) _____ (Work) _____

CURRENT EMPLOYMENT

Employer Name _____ Employer Phone _____
Employer Address (Street) _____
Employer Address (City, State, Zip) _____
Occupation _____ Length of Employment _____

PREVIOUS EMPLOYMENT (IF LESS THAN ONE YEAR AT CURRENT EMPLOYER)

Employer Name _____ Employer Phone _____
Employer Address (Street) _____
Employer Address (City, State, Zip) _____
Occupation _____ Length of Employment _____

A non-profit corporation providing Fire, Emergency Medical and Rescue services
to the citizens of Burke and Fairfax County.

EDUCATION

High School _____ Graduation Date _____ Highest Grade _____
Graduation Date _____ Highest Grade Level Completed _____
College _____ Graduation Date _____ Highest Grade _____
Graduation Date _____ Highest Grade Level Completed _____
Post Graduate Education: _____

PREVIOUS FIRE/RESCUE/EMS EXPERIENCE

Previous Fairfax Co. Fire & Rescue Dept. Station _____ Physical Category & Date _____
FF Level(s) _____ VA EMT Level _____ Expirations _____
Other Fire/Rescue Department Organization _____
Address _____
Chief _____ Phone _____ Dates From _____ To _____
Type of Experience _____
FF Level(s) _____ EMT Level & State _____ Expirations _____

CRIMINAL RECORD

Note: All applicants must complete a Background Check preformed by the Fairfax County Fire and Rescue Department Professional Standards Officer.

___ Yes ___ No Have you ever been convicted of a felony?

List Prior Criminal/Traffic Convictions (i.e., DWI, Reckless Driving). List Charges, Place, Date:

PERSONAL REFERENCES [excluding relatives]

Name _____ Relationship _____ Years Know _____
Address _____ Telephone Number _____
Name _____ Relationship _____ Years Know _____
Address _____ Telephone Number _____

The information provided is correct and complete, to the best of my knowledge. I understand that the Burke VFRD requires new members to not use tobacco products and that a background check will be conducted.

Applicant Signature _____ Date _____

FOR DEPARTMENT USE ONLY

Interviewer Remarks _____
Interviewed By _____ Date _____ Recommend Approval: YES NO
Board Review Date _____ Board Decision _____
Applicant Notified _____ Training Officer Notified _____ Sent to Vol Liaison _____
Comments _____

PLEASE SAVE THIS SHEET ALONG WITH THE LETTER ON THE FIRST PAGE

Thank you for your interest in the Burke Volunteer Fire and Rescue Department. Please keep this page so that you know what you are expected to do.

1. Please complete the member application form, the beneficiary designation form [both sections], and the employee driver record transcript form. These three documents should be sent to:

New Member Applications
Burke Volunteer Fire and Rescue Department
PO Box 228
Burke, VA 22015

You should expect a member of the New Member Committee to contact you [within two weeks of the date you mailed the form] to setup a time for your interview. If you don't hear from them, then please contact one of them using the pager numbers at the end of the information letter.

2. You will need to complete the Fairfax County Employee Driver Record Transcript Form. This form allows the county to obtain a copy of your driving record. Completion of this form is an annual requirement for all members.

3. Interviews are normally held at the Burke Volunteer Fire & Rescue Department, located at 9501 Old Burke Lake Road (across from the Burke Post Office). The first portion of the interview, which may involve other applicants, will be a general information session about the Burke VFRD, the Fairfax County Fire and Rescue Department and offer an opportunity for questions. Following the general interview, each applicant will meet individually with the New Member Committee to review the application, ensure all forms are completed, complete a pre-screening guide for a background investigation, and answer any additional questions you may have.

4. Following the interview, your application will be presented to the BVFRD Board of Directors for approval at their next regularly scheduled meeting. You will be informed of the Board's decision within a week of their meeting.

Station _____
D.O.B _____
SS# ____-____-____

FAIRFAX COUNTY GOVERNMENT EMPLOYEE DRIVING RECORD TRANSCRIPTS FORM

Pursuant to the Virginia Privacy Protection Act of 1976, you are hereby notified that you are not legally required to provide the information requested on this form. However, unless you provide the information requested on this form you will not be allowed to operate any County vehicle. If your job requires you to drive a County vehicle on a regular basis, and you are not allowed to operate a County vehicle because of your failure to provide this information, you will be subject to transfer or discipline, which could include termination of employment. The information you provide on this form will not be provided to any entity outside of the Fairfax County Government, except that the information will be provided to the Virginia Department of Motor Vehicles, or its equivalent in the state in which you are licensed, in order to obtain information about your driving record.

Check appropriate space(s) below

I currently have a valid driver's license Yes _____ No _____ Don't Know _____

I currently have less than six (6) demerits* Yes _____ No _____ Don't Know _____

Social Security Number _____/_____/_____
or

Driver's License Number _____ State Issuing Driver's License _____

Court Restrictions _____

I, _____, hereby certify that all information contained herein
(Print Name)

is true and correct. I further understand that, knowingly making false statements or misrepresentations on this form is grounds for dismissal.

Signature _____ Date _____

Witnessed By _____ Date _____

Agency Fairfax County Fire and Rescue Department

Agency Contact Person Captain Kevin L. Kincaid Agency Phone Number 703-246-2927

In lieu of providing you a copy, by my signature, I hereby authorize Fairfax County to obtain from the Division of Motor Vehicles a transcript of my driving record for verification of the above information, should the County elect to do so. This authorization is valid for only one transcript request per year as part of the annual driver's license check for DMV transcript.

Signature _____ Date _____

*** This is the threshold in Virginia. Demerit thresholds may vary in neighboring states of Maryland, West Virginia and the District of Columbia.**

VFIS[®]

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %
Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %
Name _____ Relationship _____ Date of Birth _____ Share _____ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ Date _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

VFIS[®]

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary
Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %
Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent
Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %
Name _____ Relationship _____ Date of Birth _____ Share _____ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ Date _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.