

# Island County Fire District #3

5535 Cameron Road  
Freeland, Wa. 98249  
360/321-1533 – FAX 360/321-9385 – email [admin2@icfd3.org](mailto:admin2@icfd3.org)

## VOLUNTEER APPLICATION

FIREFIGHTER \_\_\_\_\_ MEDICAL \_\_\_\_\_

DATE \_\_\_\_\_

(please type or print)

NAME

PHONE

MAILING ADDRESS

RESIDENT ADDRESS

WA DRIVER'S LICENSE #

DATE OF BIRTH

/ /

SOCIAL SECURITY #

WILL YOU BE AVAILABLE TO RESPOND TO EMERGENCY CALLS 24-HOURS PER DAY, 7-DAYS PER WEEK? \_\_\_\_\_  
IF NOT, WHAT HOURS OF THE DAY OR NIGHT, AND WHAT DAYS OF THE WEEK WILL YOU NOT BE AVAILABLE?

DO YOU HAVE A HIGH SCHOOL DIPLOMA OR A RECOGNIZED EQUIVALENT?

LIST ANY PREVIOUS FIRE OR EMERGENCY MEDICAL SERVICE TRAINING AND EXPERIENCE.

LIST ANY SKILLS THAT YOU HAVE THAT MIGHT BE OF BENEFIT TO THE FIRE DISTRICT.

LIST EMPLOYMENT DURING THE LAST TWO YEARS. PLEASE INCLUDE EMPLOYER, AND JOB DUTIES.

DO YOU HAVE ANY SENSORY, MENTAL, OR PHYSICAL HANDICAPS WHICH WOULD IMPAIR YOUR ABILITY TO PERFORM THE REGULAR DUTIES OF A VOLUNTEER FIREFIGHTER? EXPLAIN.

## REFERENCES

1. Name

Phone

2. Name

Phone.

3. Name

Phone

I UNDERSTAND THAT MISREPRESENTATION IN ANY OF MY ANSWERS OR STATEMENTS IN THIS APPLICATION WILL RESULT IN CANCELLATION OF THIS APPLICATION, AND IF ACCEPTED WILL RESULT IN DISMISSAL.

I AUTHORIZE ALL LISTED REFERENCES TO FURNISH ISLAND COUNTY FIRE DISTRICT #3 WITH ANY INFORMATION WHICH MAY INFLUENCE MY ACCEPTANCE AS A MEMBER OF THE DISTRICT.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS IN THIS APPLICATION INCLUDING DRIVER'S RECORDS, EMPLOYMENT CHECKS, AND CRIMINAL BACKGROUND INVESTIGATION.

IT IS FURTHER UNDERSTOOD THAT THIS IS AN APPLICATION ONLY AND DOES NOT IMPLY OR COMMIT THE DISTRICT IN ANY WAY TO ACCEPT ME AS A VOLUNTEER.

Signature

Date

**\*\* FIRE DISTRICT TO COMPLETE THE FOLLOWING \*\***

CANDIDATE RECOMMENDED FOR APPOINTMENT? YES NO

BATTALION CHIEF or CAPTAIN SIGNATURE

Date

CHIEF'S SIGNATURE

Date

CHAIRMAN, BOARD of FIRE COMMISSIONERS

Date



## Driving Record Request

You may use this form to request **your driving record**. We will mail your record to you or to the individual or company you request below. Mail this request and **\$5 for each record** in a check or money order payable to the Department of Licensing to:

Driver Records  
Department of Licensing  
PO Box 9048  
Olympia, WA 98507-9048

FOR VALIDATION ONLY

106-060-421-0005

Please allow two weeks for processing. If you have additional questions, contact Customer Service at (360) 902-3900.

Requestor name (Last, First, Middle Initial)		
Washington driver license number	Date of birth	(Area code) Daytime telephone number
Name of individual or company you want your drive record sent to <b>Island County Fire Protection District #3</b>		
Mailing address <b>5535 Cameron Rd</b>		
City <b>Freeland</b>	State <b>WA</b>	ZIP code <b>98249</b>
Type of record We offer the following types of driving records. Check the box beside the one(s) you need.		
<input type="checkbox"/> <b>Three-year noncommercial insurance record.</b> Available for underwriting noncommercial motor vehicle policies.		
<input type="checkbox"/> <b>Three-year commercial insurance record.</b> Available to commercial employers' insurance companies for motor vehicle underwriting purposes only.		
<input type="checkbox"/> <b>Three-year life insurance record.</b> Available to the life insurance carrier providing coverage for underwriting purposes only. Contains all traffic related commercial and noncommercial convictions, violations, and collisions.		
<input type="checkbox"/> <b>Full employment/commercial record.</b> Available to employers or prospective employers to determine employment eligibility for commercial vehicle operation. Commercial vehicle means any vehicle used primarily for the transportation of commodities, merchandise, produce, freight, animals or passengers for hire. The record shows all traffic related convictions, violations, and collisions. Some convictions remain on record for more than five years.		
<input type="checkbox"/> <b>Volunteer vanpool driver record.</b> Available to transit authorities to determine insurance and risk management requirements necessary to drive a vanpool vehicle. The record shows all traffic related convictions, violations, and collisions. Some convictions remain on record for more than five years.		
<input type="checkbox"/> <b>Volunteer for organization driver record.</b> Available to volunteer organizations to determine whether the licensee should be permitted to operate a vehicle on public highways to transport individuals under age 18, over age 65, or who are physically or mentally disabled. The record shows all traffic related convictions, violations, and collisions. Some convictions remain on record for more than five years.		
<input type="checkbox"/> <b>School bus driver record.</b> Available to school districts to determine employment eligibility for school bus operation. The record shows all traffic related convictions, violations, collisions, and suspension, revocation, and disqualification actions. Some convictions remain on record for more than five years.		
If this request is to be billed and mailed to a school district: School district name _____ Requestor code _____		
<input checked="" type="checkbox"/> <b>Complete record.</b> Available to the individual named on the driving record, attorneys, law and justice agencies, and governmental agencies. The record shows all traffic related convictions, violations, collisions, and suspension, revocation, and disqualification actions.		
<i>I declare under penalty of perjury under the laws of the State of Washington that I am the individual named above.</i>		
_____	<b>X</b>	_____
Date and place signed (Valid for four months)	Signature	

**BACKGROUND SCREENING APPLICANT INFORMATION FORM**

**PLEASE PRINT YOUR NAME AS SHOWN ON DRIVER'S LICENSE**

FIRST <i>[Black Or Blue Ink Only]</i>				MIDDLE		LAST		MAIDEN / AKA	
SOCIAL SECURITY NUMBER			STATE ISSUED			DATE OF BIRTH (MONTH/DAY/YR) <i>(For Identification Purposes Only)</i>			
DRIVER'S LICENSE NUMBER			STATE						

**PLEASE PROVIDE 7-YEARS OF ADDRESS HISTORY**

CURRENT ADDRESS	CITY	STATE	ZIP	YEARS	MONTHS
PREVIOUS ADDRESS	CITY	STATE	ZIP	YEARS	MONTHS
PREVIOUS ADDRESS	CITY	STATE	ZIP	YEARS	MONTHS
PREVIOUS ADDRESS	CITY	STATE	ZIP	YEARS	MONTHS

**PLEASE SIGN HERE**

**DATE**

*The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.*

**Island County  
 Fire District #3**  
 REQUESTING COMPANY

**Vicki Lange (360) 321-1533**  
 NAME TEL

SEARCH TYPE		
<input type="checkbox"/> COUNTY CRIMINAL	<input type="checkbox"/> CREDIT REPORT	<input type="checkbox"/> PROFESSIONAL LICENSE
<input type="checkbox"/> SSN VALIDATION	<input type="checkbox"/> REFERENCES	<input type="checkbox"/> DRUG SCREEN: RADAR 5-Panel
<input type="checkbox"/> SSN TRACE w/ address	<input type="checkbox"/> STATEWIDE CRIMINAL	<input type="checkbox"/> DRUG SCREEN: 5/7/9-Panel <input type="checkbox"/> 5 panel <input type="checkbox"/> 7 panel <input type="checkbox"/> 9 panel
<input type="checkbox"/> MOTOR VEHICLE	<input type="checkbox"/> CIVIL	<input type="checkbox"/> DRUG SCREEN: DOT 5-Panel w/MRO
<input type="checkbox"/> EDUCATION	<input type="checkbox"/> FEDERAL CRIMINAL	<input type="checkbox"/> DRUG SCREEN: 5/7/9-Panel w/MRO <input type="checkbox"/> 5 panel <input type="checkbox"/> 7 panel <input type="checkbox"/> 9 panel
<input type="checkbox"/> EMPLOYMENT	<input type="checkbox"/> WORKER'S COMP	<input type="checkbox"/> OTHER

## DISCLOSURE AND AUTHORIZATION FORM

(the "Company") will procure a consumer report and/or investigative consumer report on you for employment purposes. Personnel Profiles Employment Screening, Inc. PO Box 7495, Mesa AZ 85216 Tel. 877.225.2591 will prepare the report. The report will contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include but are not limited to: credit reports, social security number verification, criminal records check and conviction history, court, educational, and driving record history, verification of employment positions held, personal, professional, licensing and certification checks, drug testing results, etc. The information in the report will be obtained from private and public record sources, including, as appropriate, personal interviews with sources, such as neighbors, friends and associates. You may request more information respecting the nature and scope of any investigative consumer reports by contacting the Company. A summary of your rights under the Fair Credit Reporting Act is also being provided to you.

**Additional State Law Notices:** If you live or are applying for a job in California, Maine, New York or Washington, please note:

**California:** You may view and obtain the file maintained on you by Personnel Profiles upon submitting proper identification and paying the costs of duplication services, by appearing at their offices in person, during normal business hours and on reasonable notice, or by mail. You may also receive a summary of the file by telephone. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification.

**Maine:** You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

**New York:** You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

**Washington State:** If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

**Residents Of, Or For Jobs Located In, California, Minnesota And Oklahoma Only** will be provided with a free copy of any consumer reports or investigative consumer reports on you if you check the box below. You may obtain information or copies from the Company's investigative report file at any time prior to your receipt of such copies, to the extent available, by contacting Company.

**Fair Credit Reporting Act Notification** You have the right to receive a copy of your consumer credit report should one be requested for employment reasons.

I request a free copy of the report.

I request a free copy of the report.

### AUTHORIZATION

I have carefully read and understand this Disclosure and Authorization form. By my signature below, I consent to the release of consumer reports and investigative consumer reports prepared by Personnel Profiles Employment Screening, Inc., to the Company. I understand that if the Company hires me, my consent will apply throughout my employment. I understand that information contained in my job application or otherwise disclosed by me before or during my employment, if any, may be used for the purpose of obtaining consumer reports or investigative consumer reports.

**By my signature below,** I also authorize the disclosure of information concerning my employment history, earnings history, education, credit history, credit capacity and credit standing, driving record history and standing, criminal records check and conviction history, pre-employment drug test results, and all other information deemed pertinent by the consumer reporting agency to the agency by the following: my past or present employers; learning institutions, including colleges and universities; law enforcement agencies; federal, state and local courts; the military; credit bureaus; and, motor vehicle records agencies.

**PLEASE FILL OUT AND SIGN BELOW**

LAST NAME

FIRST NAME

MIDDLE NAME

SSN NUMBER

PLEASE SIGN HERE

DATE

**CONFIDENTIAL**

**DISCLOSURE REPORT**

RCW 43.43.834(2)\* requires the Fire Protection District, at the time it accepts an application for the position of volunteer or paid fire fighter, to obtain the following information from the applicant if the applicant, when hired, may have unsupervised access to children under sixteen (16) years of age or developmentally disabled persons or vulnerable adults during the course of employment or where a volunteer may have access to groups of five (5) or fewer children under twelve (12) years of age, or three (3) or fewer children between twelve (12) and sixteen (16) years of age, or developmentally disabled persons or vulnerable adults. To comply with the statutory requirements, please provide the following information under oath:

- 1. Have you been convicted of any crime against children or other persons?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 2. Have you been convicted of crimes relating to financial exploitation of a vulnerable adult?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 3. Have you been found in any dependency action under RCW 13.34.040\* to have sexually assaulted or exploited any minor or to have physically abused any minor?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 4. Have you been found by a court in a domestic relations proceedings under Title 23 RCW\* to have sexually abused or exploited any minor or to have physically abused any minor?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 5. Have you been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 6. Have you been found by a court in a protection proceeding under chapter 74.34 RCW\*, to have abused or financially exploited a vulnerable adult?  
Yes \_\_\_\_\_ NO \_\_\_\_\_

Dated: \_\_\_\_\_  
Applicant

STATE OF WASHINGTON,	)	ACKNOWLEDGEMENT
	) ss.	OF
County of _____	)	INDIVIDUAL

I certify that I know of/have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the instrument.

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

\_\_\_\_\_  
Notary Public in and for the  
State of Washington,  
residing in \_\_\_\_\_.  
My appointment expires \_\_\_\_\_.

\* See reverse for explanation.

A crime against children or other persons is defined by the statute as:

"...a conviction of any of the following offenses: Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; first or second degree rape of a child; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; or any of these crimes as they may be renamed in the future".

A crime relating to financial exploitation is defined by statute as:

"...conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes as they may be renamed in the future."

If you are offered a position as a paid employee or volunteer with the District, the District may under RCW 43.43.832 and .834 submit an inquiry to the Washington State Patrol to conduct a records check to verify the answers provided on the reverse side. You will be notified within ten (10) days after a response is received from the State Patrol of the nature of the response and be provided a copy of the response at your request. The District will use this information and record only to make the initial employment decision and for no other purpose.



## QUALIFICATIONS FOR ENTERING STATE EMERGENCY MEDICAL TECHNICIAN TRAINING

- 1 ALL individuals applying for admission to a Washington Emergency Medical Services training course must meet ALL of the following requirements or they will not be eligible to enroll in the course:
- A. You must be 18 years of age at the beginning of the EMT Course.
  - B. You must have a high school diploma or equivalency qualification.
  - C. You must have completed a Standard First Aid Course recognized by the District.
  - D. You must have the physical strength to perform the normal functions of an Emergency Medical Technician.
  - E. You must be an active member of one of the following emergency medical services entities in the State of Washington:
    - (1) Fire Department;
    - (2) Ambulance Service;
    - (3) Aid Vehicle Service;
    - (4) any Police Department;
    - (5) Military or civilian personnel involved in search and rescue to the general public.
  - F. If you need training to qualify for employment in the state of Washington in any of these positions in E(1) through (5) you will be eligible to enroll in the class. You will not be eligible for state certification as an Emergency Medical Technician until you become a functioning member of one of the identified agencies in E(1) through (5) in the State of Washington.

I have read and understand all the requirements that are mandatory for any enrollment in this BLS training class.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

# Fire Protection District No. 3

## Island County

5535 Cameron Road • Freeland, WA 98249  
360/321-1533 • Fax 360/321-9385 • www.icfd3.org

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Freeland • Clinton • Maxwelton • Saratoga • Bayview • Langley

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### MEMBER APPLICATION FOR ACCESS OR COMPUTER USE

Members Name:

Members Station Number:

Cell Phone Number:

Home Phone Number:

Home or work E-Mail: (print in CAPS)

The Departments' Security Systems are secure; this includes the website, local and administrative computers & programs, building access and alarm systems. In an effort to keep things simple for all users of the above equipment we have developed a single password system for all your needs. If your application for access is approved, you will be notified of your access code and how to use it.

The department provides computer access to all members who wish to have access to the systems; all officers are required to have access. If you elect to have access to the system, by this request, you agree to comply with the districts policies and procedures and specifically SOP-100.02. This application is not valid unless a signed copy of SOP-100.02 is attached. Should someone see your password; you must contact the District Office as soon as possible to have your password changed.

I would like access to: Buildings  Computers   
I would like a copy of my Department e-mail sent to my e-mail address above: Yes  No

I AGREE to the above:

\_\_\_\_\_  
Signature Required Date

Station Officers Name: \_\_\_\_\_ Date: \_\_\_\_\_

Station Officers Signature: \_\_\_\_\_

**Please return this form to your station officer for approval.  
After it is signed by a station officer, deliver to Captain Beck or 300**

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Station Officer  Computer Services Received (Date) \_\_\_\_\_ SOP100.02 Verified \_\_\_\_\_  
CS Released to User \_\_\_\_\_  Administration File \_\_\_\_\_

<b>COMPUTER USAGE, PROCEDURES, AND GUIDELINES</b>	<b>100.02</b>
	Ref Policy: 4.12
	Developed: July 1, 2004      Changes:
	Approved: _____      Date: ___/___/___

NETWORK

1. All use of the District's computer network including access to the Internet and its e-mail system (the "System") must be in support of communication consistent with the mission of Fire District #3 (the "District"). The District reserves the right to prioritize use and access to the System.
2. All uses of the System must be in conformity to state and federal law, network provider policies and licenses, and District procedure. Use of another organization's network or computing resources must additionally comply with the rules appropriate for that network. Use of the System for commercial solicitation or other commercial purposes is prohibited. Use of the System for charitable purposes must be approved in advance by the Fire chief.
3. The System constitutes public facilities and may not be used to support or oppose political candidates or ballot measures.
4. No use of the System shall serve to disrupt the operation of the System or others; System components including hardware or software shall not be destroyed, modified, or abused in any way (including without limitation, by the creation or uploading of viruses or other harmful code or intentional destruction of others' data).
5. Malicious use of the System to harass other users or gain unauthorized access to any computer or computing system and/or damage the components of a computer or computing system is prohibited.
6. Users are responsible for the appropriateness and content of material they attempt or actually do access, store, transmit, or publish using the System. Abusive, libelous, or defamatory statements, hate mail, harassment, discriminatory remarks, and other antisocial or illegal behaviors are expressly prohibited.
7. Use of the System to attempt to or to actually access, store, transmit or publish obscene, pornographic, or sexually explicit material, whether visual, textual, or in any other medium is prohibited.

## ISLAND COUNTY FIRE DISTRICT #3 – STANDARD OPERATING PROCEDURES

<b>COMPUTER USAGE, PROCEDURES, AND GUIDELINES</b>	<b>100.02</b>
	Ref Policy: 4.12
	Developed: _____ Changes: _____
	<u>SEE PAGE 1 FOR DATES AND SIGNATURE</u>
	Approved: _____ Date: ___/___/___

### ELECTRONIC MAIL

1. Electronic Mail (“e-mail”) is intended to be used for communication purposes. Email messages sent or received for personal or other purposes will be treated no differently from other messages. Consequently, email should not be used for any information that the user desires to keep personal or private.
2. Despite the password and other security provision, it must be understood that email is not necessarily secure, private or confidential. For example, it is possible for any message sent by a user to be forwarded on to anyone else on the Internet, with or without the knowledge of the original sender. Even after an email has been deleted, it can still be possible to retrieve it and read it. The District reserves the right to access and view any email messages on its system and employees should not expect their email messages, received or sent, to be private. Therefore, users should avoid sending anything in email that might cause harm to themselves or another if revealed to persons other than the intended recipient.
3. The security provision of the email system must be honored at all times. For example, one should not attempt to gain access to other people’s messages to satisfy idle curiosity or other personal interests.
4. Good judgment should always be employed in using email. In addition to the general guidelines contained in this S.O.P. the following practices are specifically forbidden. This is not an exclusive list; other email practices that do not meet the District’s expectations are prohibited.
  - a. Intentional impersonation and/or misrepresentation as to the identity of a sender or receiver of email.
  - b. Modifying a message and forwarding without noting the changes (i.e. additions, deletions, modifications to the content, etc.).
  - c. Bypassing the user-security mechanisms of the email system in a malicious manner (such as creating bogus accounts or “snooping” through mail addressed to other people).
  - d. Placing information on the email system that would defame, or portray in a false light, the sender or recipient of an email message.

ISLAND COUNTY FIRE DISTRICT #3 – STANDARD OPERATING PROCEDURES

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	Approved: _____ Date: __/__/__

SECURITY

1. System accounts are to be used only by the authorized owner of the account for the authorized purpose. Users may not share their password with another person or leave an open file or session unattended or unsupervised. Account owners are ultimately responsible for all activity under their account.
2. Users shall not seek information, obtain copies of, modify files, other data, or passwords belonging to other users, or misrepresent other users on the System, or attempt to gain unauthorized access to the System.
3. Communications and files may not be encrypted so as to avoid security review.
4. If any user becomes aware of a security problem on the Internet, they should notify the Webmaster and refrain from demonstrating the problem to other users.

PERSONAL SECURITY

1. Personal information such as addresses and telephone numbers should remain confidential when communicating through the System.

COPYRIGHT

1. The unauthorized installation, use, storage, or distribution of copyrighted software or materials using the System or on District computers is prohibited.

GENERAL USE

1. Diligent effort must be made to conserve System resources. For example, users should frequently delete email and unused files.
2. No person shall have access to the System without having read and signed the District Internet Access and email agreement. A signed User Informed Consent Form must be on file with the District.
3. From time to time, the District will make a determination on whether specific uses of the System are consistent with the regulations stated above. The District reserves the

ISLAND COUNTY FIRE DISTRICT #3 – STANDARD OPERATING PROCEDURES

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	<u>SEE PAGE 1 FOR DATES AND SIGNATURE</u>
	Approved: _____ Date: __/__/__

right to modify or revise these regulations at any time. Under prescribed circumstances non-staff use may be permitted, provided such individuals demonstrate that their use furthers the purpose and goals of the District. **For security and administrative purposes, the District reserves the right for authorized personnel to review the System use and file content, including, without limitation, the contents of email messages.** The District reserves the right to remove a user account on the System to prevent unauthorized activity.

**Violation of any of the conditions of use described in the S.O.P. is cause for disciplinary action up to and including termination of employment or removal from active volunteer service.**

ISLAND COUNTY FIRE DISTRICT #3 – STANDARD OPERATING PROCEDURES

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	Approved: _____ Date: ___/___/___

**Form 100.2**

**Island County Fire District #3**

**INTERNET ACCESS AND EMAIL AGREEMENT**

Island County Fire District #3 has instituted Internet and email. In order to provide a healthy working environment for everyone, we ask that you comply with the following guidelines:

1. Island County Fire District #3 provides Internet access and email primarily for purposes related to Fire District 3 and your position. Use of Fire District #3's equipment, Internet access and email for non-district related purposes during business hours is inappropriate. Common sense and good judgment should guide secondary usage. At least implicitly, as far as our vendors, customers, and others outside of Fire District #3 are concerned, you are a representative of Fire District #3. Therefore, should you wish to engage in a time consuming, controversial, or private topic, you must do so on your own time with your own account and equipment. Even then, you should not identify yourself as Fire District #3 personnel when referring to Fire District policies, issues, responsibilities, etc., unless you have been specifically authorized by Fire District #3 to speak on behalf of the District.
2. All use of Fire District 3's computer network, Internet access, and email must be in conformity to state and federal law and any regulations published by Fire District #3 from time to time. Users are responsible for the appropriateness and content of material they store, transmit, or publish using Fire District 3's computer network, Internet access, and email. Without limiting the foregoing, the following is prohibited:
  - a. Malicious use of Fire District #3's computer network, Internet access, and email to harass others or gain unauthorized access to any computer or computing system.
  - b. Abusive, libelous, or defamatory statements.
  - c. Hate mail, harassment, or discriminatory remarks.
  - d. Accessing, transmission, or storage of pornography, or any obscene text or images.
  - e. Unauthorized installation, use, storage, or distribution of copyrighted software or material.
  - f. Antisocial or illegal behaviors.

ISLAND COUNTY FIRE DISTRICT #3 – STANDARD OPERATING PROCEDURES

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g. All other misconduct outlined in S.O.P. 100.2 copy attached.

Use of another organization’s network or computing resources must additionally comply with the rules appropriated for that network or organization.

3. Fire District #3 reserves the right to modify or revise these regulations at any time, with or without notice. For security and administrative purposes, Fire District #3 reserves the right for authorized personnel to audit, access, and if necessary, disclose any use of Fire District #3’s equipment and facilities and content of any files stored there on, including, without limitation, access logs, and email messages. The use of Fire District #3’s computers Internet access, and email is a privilege, not a right. Inappropriate use may result in a cancellation of those privilege or other penalties and could result in disciplinary action, up to and including termination of employment or removal as a volunteer. In addition Fire District #3 reserves the right to restrict or deny access at work to anyone at any time.

**I have read and understand the above guidelines and agree to follow them. I specifically understand that any violations of the attached S.O.P. 100.02 guidelines herein and in S.O.P. 100.2 can result in disciplinary action up to and including termination of my employment or removal as a volunteer.**

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**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.

**Specifying Beneficiaries**

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

\* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

\*\* Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>WASHINGTON FIRE COMMISSIONERS ASSOCIATION – Volunteers</b>		Group Number(s) <b>645730</b>	
	Your Address			City	State	ZIP
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation
<b>LIFE</b>	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> <b>Life Insurance</b> <input checked="" type="checkbox"/> Life with AD&D Employer Paid					
	<i>This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>					
<b>BENEFICIARY</b>	Primary - Full Name		Address	Soc. Sec. No.	Relationship % of Benefit	
	Contingent - Full Name		Address	Soc. Sec. No.	Relationship % of Benefit	
<b>CHANGE</b>	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i>					
	<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change		<input type="checkbox"/> Other _____	
<b>SIGNATURE</b>	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.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
<b>Human Resources Department - Complete this section. Retain form for your records.</b>						
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	

## 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 any 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.

**COMBINED INSURANCE COMPANY OF AMERICA**

**Application for Life Insurance Coverage**

Home Office: Chicago, Illinois

**FORM #36002**

I am applying for this coverage based on the following health and employment information:

Application Date: \_\_\_\_\_

ACTION REQUESTED: <input checked="" type="checkbox"/> New Enrollment <input type="checkbox"/> Add Rider <input type="checkbox"/> Benefit Increase					
EMPLOYEE'S (Proposed Insured, Owner) NAME (First MI Last)		<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip) c/o VFIS, PO Box 2726, York PA 17405					
Social Security No.	EMPLOYER ISLAND COUNTY FIRE PROTECTION DISTRICT #3 LOSAP	Hire Date: Mo/Day/Yr	Employee ID#	Gross Annual Income	
Occupation Volunteer Firefighter	Has the employee used tobacco in any form in the last 12 mos.? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Height ft. in.	Weight lbs.	
BENEFICIARY'S Full Name ISLAND COUNTY FIRE PROTECTION DISTRICT #3 LOSAP	Relationship LOSAP	CONTINGENT BENEFICIARY'S Name		Relationship	

DEPENDENT'S (Proposed Dependent Insured) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age	State of Birth
Dependent's Occupation	Relationship to Employee	Has the dependent used tobacco in any form in the last 12 mos.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Height ft. in.	Weight lbs.
BENEFICIARY'S Full Name	Relationship	CONTINGENT BENEFICIARY'S Name		Relationship	

AMOUNT OF INSURANCE BEING APPLIED FOR: (including the account value)	Premium - Mode
\$10,000.00	Annual
<b>Total Premium:</b>	

Do you elect the Automatic Increase feature (premiums increase \$1 a week for 5 years on policy anniversary)? Yes  No

1. Are you employed in your primary occupation for less than 30 hours each week?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<i>Answer questions 2, 3, and 4 if applying on a Non-Guaranteed issue basis.</i>	
2. Have you or your Dependent been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or been tested positive for HIV?	Employee: Yes <input type="checkbox"/> No <input type="checkbox"/> Dependent: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. Have you or your Dependent missed more than 5 consecutive days of work due to accident or sickness during the past 6 months?	Employee: <input type="checkbox"/> No <input type="checkbox"/> Dependent: <input type="checkbox"/> No <input type="checkbox"/>
4. Have you or your Dependent received treatment in an outpatient or emergency facility or been hospitalized during the past 12 months?	Employee: <input type="checkbox"/> No <input type="checkbox"/> Dependent: <input type="checkbox"/> No <input type="checkbox"/>

Answer questions 5 and 6 if "Yes" is answered to question 3 or 4, or if applying on a Non-Express Issue basis.

5. Have you or your Dependent been convicted of reckless driving or driving under the influence of alcohol or drugs in the last 5 years? List your Driver's license # and state:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you or your Dependent had any advice, treatment, or taken any prescription medication for any heart condition, cancer, stroke or any other sickness, injury or defect, excluding flu, colds and routine physicals in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If "Yes" is answered to question 6, explain on Page 2. In any case, please provide information on your physician.

Will the policy applied for replace or cause the change of any existing Life Insurance or Annuity contracts? Yes  No

It is very important that you review the application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

- The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
- I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information Practices and Accelerated Benefit Disclosure.

X \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Employee

I, the authorized agent, have on the Date of Application recorded the information as given to me by the Employee. To the best of my knowledge and belief the policy being applied for will - will not  replace any existing insurance. I have delivered the Notice of Information Practices and Accelerated Benefit Disclosure. I have no knowledge of any unfavorable medical history not recorded on this Application.

Signature of Licensed Agent \_\_\_\_\_ Code # GEZN



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## SUGGESTED WORDING FOR DESIGNATED BENEFICIARIES

TYPE	LANGUAGE
1. One beneficiary of a class	Jane Ann Jones, spouse, 100%
2. Two or more beneficiaries of a class	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
3. Unnamed children	Children of the Participant
4. Unequal distribution (always as percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%
5. Participant's Estate	Executors or Administrators of the Participant's Estate
6. Trustee	ABC Bank, as trustee under trust agreement dated _____.
7. Testamentary Trustee	The qualified testamentary trustee(s), under the Participant's Last Will and Testament.

If death occurs and a minor child (a person under the age of majority) or estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.



**Combined Insurance Company of America**

5050 N. Broadway

Chicago, IL 60640

Flexible Premium Adjustable Life Insurance Policy (Form #36002)

Applicants Name: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

The undersigned Applicant acknowledges that no illustration conforming to the coverage applied for was provided and understands that an illustration conforming to the coverage as issued will be provided at the time of the policy delivery.

Applicant: \_\_\_\_\_

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

The undersigned Agent certified that no illustration conforming to the coverage applied for was used in this sale.

Agent: \_\_\_\_\_

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

This form MUST accompany the application.

**COMBINED INSURANCE COMPANY OF AMERICA  
5050 Broadway, Chicago, Illinois 60640**

**ACCELERATED DEATH BENEFIT DISCLOSURE**

Your policy contains an accelerated benefit rider that allows the Owner to receive the proceeds of the policy if the Insured, prior to the attainment of age 64, is diagnosed with a terminal condition. A terminal condition means a condition which a licensed physician has certified is expected to result in death within 24 months or less after the date of certification.

Upon receipt of a request for a full or partial accelerated payment, the requested proceeds of the policy, less 12 months interest at 6.75%, will be paid to the Owner. For partial payments, the cash values and premium payment under the policy shall be reduced. Combined will issue an amended policy data page. If full payment of the proceeds is requested, the policy will terminate without value. No other payments will be made under the policy.

**If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.**

**This accelerated benefit is intended to qualify under 26 U.S.C. §101(g) of the Internal Revenue code of 1986, as amended.**

The policy provides that payment will not be made if the Owner requests accelerated benefits involuntarily to meet the claims of creditors, whether in bankruptcy or otherwise, or to keep or obtain a government benefit or entitlement.

We recommend that you obtain the advice of your tax advisor and/or attorney if you have any questions about this benefit.

I acknowledge receipt of this disclosure given to me by the undersigned agent.

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Signature of Applicant

Date

Signature of Agent

Form No. 330006-WA

**White Ply - Home Office Copy**

**Yellow Ply - Applicant's Copy**