YORK AREA UNITED VOLUNTEER FIRE AND RESCUE

Application for Volunteer Membership

Applying for Membership with: ❑Springettsbury ❑Grantley ❑Victory ❑Alert

Membership Type: Mark only ONE with an "X"

☐**FIRE** ☐ **FIRE POLICE** ☐ **SOCIAL**

APPLICATION FEE: $25.00 Payable by cash or check made out to York Area United Fire and Rescue

Do You Have Certification or Training in firefighting or EMS? YES_____ NO_____

You May Volunteer In Multiple Capacities (Fire, EMS, etc.) Once You Are a Permanent Member

I am at least 16 Years of Age. YES_____ NO_____ (If not 16 years of age, a parent or legal guardian must provide notarized written permission for you to submit a membership application)

Contact Information	
Name:	
Address: City: State: Zip:	
Home Phone:	Cell Phone:
Email Address:	Other Phone:
Emergency Contact In Case of Illness/Injury : Name:	
Phone Number:	
Highest Level of Education:	
(if currently enrolled as a student. please indicate current grade or college year)	
Employer:	
Occupation:	
Military Experience: (list branch. rank, & years of service):	

MEMBERSHIP SECRETARY'S CHECK-LIST

❑Background Check & Reference Checks Completed
❑Completed 6 months' Probation (Dates:_____________)
❑Completed 12 months' Probation (Dates:_____________)

❑ Approved Application
❑ ID Rejected Application
❑ Cash/Check Enclosed

Signature & Date:_______________________________________

Specialized Training or Experience

Please list in this section any experience, training or certification(s) as related to fire, EMS, or ancillary support services to the organization (example: fund raising, public relations, etc.).

FIRE	Certification Type	State	Certification Number or School Name

FIRE POLICE	Certification Type	State	Certification Number or School Name

EMS	Certification Type	State	Certification Number

CPR	Certification Type	Red Cross or AHA	Expiration Date

Vehicle Operator's Licenses

License Type	License Number	Place of Issue	Expiration Date	Restrictions

IMPORTANT: Provide a Photocopy of Each License

References

List the names and telephone numbers of three references including employers, school, personal, or other fire/EMS/public safety organizations. Do not use family members as references.

Name of Reference	Name of Organization	Phone Number	Years

Current or Previous Fire/EMS/Fire Police Membership Affiliations

Please list any current or past membership(s) with fire or EMS organizations. If you have been terminated from these organizations, indicate reason(s) or circumstances.

Acknowledgements - Auto Insurance & Driver's Record

Have you ever been denied insurance or a license or have you ever had a license suspended or revoked within the past three (3) years for non-medical reasons? (check one) YES_____ NO_____

If yes, explain fully:

____

____

____

Have you ever had automobile insurance withdrawn or revoked or have you ever been refused automobile insurance, within the past three (3) years? (check one) YES_____ NO_____

If yes, explain fully:

____

____

____

Acknowledgements - Criminal Record

Have you ever been arrested, charged, cited, or held by law enforcement authorities or juvenile authorities in The United States, or in a foreign country, regardless of whether the citation or charges was/were dropped or dismissed, or you were found guilty? (check one)

YES_____ NO_____

If yes, explain fully:

____

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____

____

Acknowledgements - Medicare/Medicaid Fraud

Have you ever been excluded from participating in any state or federal health care program including Medicare or Medicaid? (check one)

YES_____ NO_____

If yes, explain fully:

____

____

____

Agreement

I hereby state the information contained in this application is true and correct to the best of my knowledge. Any false statements entered on this application will be grounds for immediate removal from membership with York Area United Fire and Rescue.

____

Applicant's Signature Date

York Area United Fire and Rescue considers all applicants without
regard to race, color, religion,
creed, gender, national origin, age, disability,
veteran status
or any other legally protected status

IMPORTANT NOTICE:

Applicant will have no more than 60 days from the date of notification to schedule and complete the physical. Failure to complete within the time frame will result in the expiration of the application. The applicant will then have to meet with the Fire Chief, or his designee, before continuing in the process.

SP 4-164A (7-2015)

PENNSYLVANIA STATE POLICE

REQUEST FOR CRIMINAL RECORD CHECK

VOLUNTEER ONLY

1-888-QUERYPA (1-888-783-7972)

This form is to be completed in ink by the requester – (information will be mailed to the requester only). If this form is not legible or not properly completed, it will be returned unprocessed to the requester. *A response may take four weeks or longer.*

FOR CENTRAL REPOSITORY USE ONLY **CONTROL NUMBER**
AFTER COMPLETION MAIL TO: PENNSYLVANIA STATE POLICE CENTRAL REPOSITORY – RCPU 1800 ELMERTON AVENUE HARRISBURG, PA 17110-9758

TRY OUR WEBSITE FOR A QUICKER RESPONSE
https://epatch.state.pa.us

REQUESTER NAME	York Area United Fire and Rescue
ADDRESS	50 Commons Drive
CITY/STATE/ ZIP CODE	York, PA 17402
TELEPHONE NO. (AREA CODE)	(717) 718-2383

SUBJECT OF RECORD CHECK				
(FIRST)	(MIDDLE)	(LAST)		
MAIDEN NAME AND/OR ALIASES	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	SEX	RACE
VOLUNTEER'S AGENCY/ORGANIZATION (MANDATORY) York Area United Fire and Rescue		TELEPHONE NUMBER 717-718-2383		

The Pennsylvania State Police response will be based on the comparison of the data provided by the requester against the information *contained in the files of the Pennsylvania State Police Central Repository only.*

By signing this form, I verify that I am submitting this request for criminal history record information in connection with my status as an unpaid volunteer. I understand that the $8 fee is being waived because of my status as an unpaid volunteer.

REQUESTER SIGNATURE (*Signature required for processing*)	DATE

WARNING: 18 Pa.C.S. 4904(b) UNDER PENALTY OF LAW - MISIDENTIFICATION OR FALSE STATEMENTS OF IDENTITY TO OBTAIN CRIMINAL HISTORY INFORMATION OF ANOTHER IS PUNISHABLE AS AUTHORIZED BY LAW.

YORK AREA UNITED FIRE AND RESCUE

HIPPA ACKNOWLEDGEMENTS

Policy on Confidentiality & Dissemination of Patient Information & Staff Member Verification

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. YAUFR prohibits the release of any patient information to anyone outside the department except in limited circumstances and discussions or disclosures of protected health information (PHI) within the organization should be limited to the minimum necessary that is needed for the recipient of the information to perform their job. Acceptable uses of PHI within the organization include but are not limited to peer review, internal audits, quality assurance, and billing. I understand that YAUFR provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of YAUFR patients. I understand personal information and that such information may exist in a variety of forms such as electronic, oral, written, fax, or photographic and that all such information is strictly confidential and protected by federal and state laws that prohibit its unauthorized use or disclosure.

I have reviewed the confidentiality policies and procedures set in place by YAUFR and agree I will comply with such policies and procedures during my entire volunteer experience with YAUFR. If I, at any time, knowingly or breach the patient confidentiality policies and procedures, I agree to notify the YAUFR HIPPA Privacy Officer Liaison immediately. In addition, I understand that breach of patient confidentiality or privacy may result in disciplinary action up to and including suspension or termination as a volunteer with YAUFR. Upon separation as a volunteer for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession.

I have read and understand all privacy policies and procedures that have been provided to me by YAUFR. I agree to all conditions as a volunteer set forth in this agreement.

Signature: ____ Date:__________________

Printed Name: ____

YAUFR HIPAA Privacy Officer Liaison

Chief Daniel Hoff is the contact at YAUFR for all HIPAA or privacy act questions or concerns. Please contact Chief Hoff at the station if you suspect violations.

HIPAA rules and regulations apply to anyone in contact with patient information regardless of employment or volunteer status.

NOTICE OF RIGHTS AND DUTIES

Pennsylvania law requires employers to notify employees of their rights and duties regarding medical services provided under the Workers' Compensation Law (the Act). This notice will provide you a summary of the applicable provisions of the Act:

- Your employer has established a medical panel, which includes at least six designated health care providers, no more than four of whom are coordinated care organizations and no fewer than three of whom are physicians. The employer has not included on this list a physician or health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list.
- You have a duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- You have the right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from the designated provider during the 90-day period.
- You have the right, during this 90-day period, to switch from one health care provider on the list to another health care provider on the list, and that all treatment shall be paid for by your employer.
- You have the right to seek treatment from a referral provider if a designated provider refers you, and your employer shall pay for treatment rendered by the referral provider.
- You have the right to seek emergency medical treatment from any provider, but subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
- You have the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but these services shall be at your expense for the applicable 90 days.
- You have a right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by your employer, if it is reasonable and necessary.
- After ninety (90) days from the date of first treatment, you have a duty to notify your employer of treatment by a nondesignated provider within 5 days of the first visit to that provider. Your employer may not be required to pay for treatment rendered by the nondesignated provider prior to receiving this notification. However, your employer shall pay for these services once notified, unless the treatment is found unreasonable by a utilization review organization.
- You have the right to seek an additional opinion from any health care provider of you choice when a designated provider prescribes invasive surgery for you. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, you shall determine which course of treatment to follow. If you opt to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on your employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

I hereby acknowledge that my employer has provided me with a copy of this "Notice of Rights and Duties". I have been informed of and I understand my rights and duties pertaining to medical treatment for work related injuries thereunder. This notice was presented to me at (check one):

☐ Time of hire or orientation

☐ Immediately after the injury, or as soon thereafter as possible

☐ Other: ______________________________

______________________________ ______________
Employee Signature Date

______________________________ ______________
Employer Representative Date

IMPORTANT NOTICE TO EMPLOYEES
In Case of Work-Related Injury

This notice shall serve to advise you of your rights and responsibilities under the Pennsylvania Worker's Compensation Act.

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prostheses, including training in their use.

2. In order to insure that your related medical treatment will be paid for by your employer or the insurance company, you must select from one of the licensed physicians or practitioners of the healing arts on the attached list of Panel Providers.

3. You must continue to visit one of these persons listed on the list of Panel Providers, if you need treatment, for ninety (90) days from the date of your first visit.

4. After this ninety (90) day period, if you still need treatment and your employer has provided a list as set forth on the attached sheet, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action with five (5) days of your visit to the physician of your choice. Failure to do so will relieve the employer from liability for payment of those services.

5. If one of the providers listed on the list of Panel Providers refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.

6. If you are faced with a medical emergency, you may secure assistance from a hospital or physician or licensed practitioner of the healing arts of your choice on the list. If no hospitals are listed, you may go to a hospital of your choice.

7. If invasive surgery is recommended by the designated physician, you are allowed a second opinion by a physician of your choice. If the second opinion differs from the first, you have the right to determine which course of treatment to follow, provided that the second opinion provides a specific and detailed course of treatment. If you choose to follow procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the second opinion visit.

The name of your employer's insurance carrier (or third party administrator) is:

State Workers' Insurance Fund
1171 S. Cameron St., Room 111
Harrisburg, PA 17104
Phone: (717) 787-3843 Fax: (717) 772-2121
www.dli.state.pa.us

Please sign where indicated to verify that you understand the rights and responsibility outlined in this notice.

I have read the above and understand the rights and responsibilities explained to me therein.

Signature of Employee/Date

Witness/Date

Workers' Compensation Information

The following information is being provided to you in compliance with 34 Pa.Code § 121.3b.

1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

3) You should report immediately any injury or work-related illness to your employer.

4) Your benefits could be delayed or denied if you do not notify your employer immediately.

5) If you claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Employee's Signature: ______________________________

Date: ______________________________

YORK AREA UNITED FIRE AND RESCUE

WORKER'S COMPENSATION VOLUNTEER NOTIFICATION

Worker's Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job (volunteer venture). YAUFR shall provide payment for reasonable surgical and medical services, services rendered by physicians or the health care providers, medicines, supplies, as and when needed.

YAUFR, in compliance with the Worker's Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from the closest hospital, physician, or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on the YAUFR physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again revisit YAUFR panel of physicians and select a new physician. If you do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, YAUFR will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician of your choice opinion differ, and you choose that option, the panel physician will abide the by same for 90 days.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify YAUFR within five (5) days of your first visit with your new provider. Failure to notify YAUFR will relieve YAUFR of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Worker's Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Worker's Compensation Act.

____ ________________________

Volunteer's Signature Date

YORK AREA UNITED FIRE AND RESCUE

Office of the Fire Chief

Daniel J. Hoff, Fire Chief

PERSONAL INFORMATION UPDATE RECORD-VOLUNTEER

Name ______________________________
Last *First* *Middle*

Address ______________________________

____

Home Phone ____________________

Cell Phone ____________________

Birthdate ____________________

Gender Male Female
Circle one

Employee Number ____________________

Age ____________________

Driver's License # ____________________

State of Issue ____________________

Circle One:
DUTY: Firefighter Fire Police Social Member

EMAIL:

Emergency Information

Emerg. Contact Name ____________________

Address ____________________

____

Home Phone ____________________

Cell Phone ____________________

Other ____________________

Relationship ____________________

Family Physician ____________________

Office Address ____________________

____

Physician Phone # ____________________

Blood Type ____________________