BOROUGH OF FAIRVIEW

Fire Department

59 Anderson Avenue, Fairview, NJ 07022

New Member Onboarding Checklist

Required steps to complete before onboarding is finalized

Member Name: _____ **Date Paperwork Dropped Off:** _____

Eligibility Requirements: Member must be at least 18 years of age and reside within 3.5 miles of Fairview.

Note: All completed paperwork must be brought to Monique Berisha, Borough Clerk's Office.

TO BE COMPLETED BY NEW MEMBER

☐ **Drug Test & Physical — Completed at Holy Name Hospital**
Member must schedule and complete a drug test at Holy Name Occupational Health prior to the start date. Call 201-833-7200 to schedule. Bring the Relief Association Physical form to this appointment. Results are submitted directly to the Borough Clerk's Office from Holy Name.

☐ **Contact Information Form**
Form must be completed in full.

☐ **Background Check — Fairview Police Department**
Stop by the Fairview Police Department for a fingerprint check, or call 201-943-2100 to schedule.

☐ **Drug, Motor Vehicle Fleet & Personnel Policy Manual — Signed & Completed**
Member must read, sign, and return the signature page of the Policy Manual. Manuals will be emailed.

☐ **Lincoln Life Insurance Form**
Form must be completed in full.

☐ **I-9 Form — Employment Eligibility Verification**
Member must complete the form in full.

☐ **W-4 Form — Federal Tax Withholding**
Member must indicate withholding allowances. Form must be signed and dated.

☐ **New Jersey State Firefighter's Association Application**
Form must be completed in full.

☐ **Fairview Fire Department Firemen's Relief Association Application & Physical**
Member must complete the application and bring the physical form to Holy Name Occupational Health at the time of the drug test — the physical is completed there in the same visit.

☐ **Copy of Driver's License**

☐ **Copy of Social Security Card**

FOR BOROUGH USE ONLY — TO BE COMPLETED BY ADMINISTRATION

☐ **Confirm & File Drug Test Results**

☐ **Create Personnel File for Member**

☐ **File Resolution to Personnel File**

☐ **Email Policy Manual to Member**

☐ **Have Mayor Sign Fire Applications**

☐ **Have Clerk Sign Fire Applications**

☐ **Have Chief Sign Fire Applications**

☐ **File Copy of Fire Applications in Personnel File**

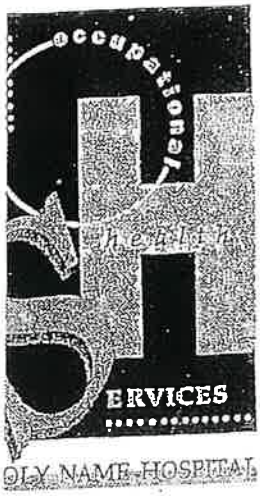
☐ **Email Copy of Personnel Documents to Payroll**

☐ **Input Personnel Information in Spreadsheet**

☐ **Provide Signed Documentation to Fire Chief**

☐ **Send Email to Doug That Documents Are Ready**

Holy Name Hospital



Occupational Health Services

718 Teaneck Road
Teaneck, NJ 07666

7:30 am - 6:00 pm
Mon - Fri
Injuries: 7:30 - 4:30 pm
Drug Tests: 7:30 - 5:30 pm
Physicals by Appointment
201 - 833 - 7200
FAX 201- 833-7073

Treatment Authorization Form

Date: _____

Company Name: _____

Address: _____

Company Phone #: _____

Authorizing Signature: _____

Print Name: _____

Name of Patient: _____

Nature of Complaint/Visit: _____

_____

Borough of Fairview
Contact Information

Full Name: _____

Address: _____

_____

Cell Number: _____

Other Number: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____

Emergency Contact: _____

Emergency Contact Relationship: _____

Emergency Contact Phone Number: _____

Department: _____

Job Title: _____

Date: _____

Borough of Fairview
Background Check

Please visit the Fairview Police Department to schedule a Background Check

Fairview Police Department
59 Anderson Avenue, 1st Floor
Fairview, NJ 07022
(201) 943-2100

BOROUGH OF FAIRVIEW
59 ANDERSON AVENUE, FAIRVIEW, NJ 07022

Receipt for Drug, Motor Vehicle Fleet and Personnel Policies & Procedure Manual

I acknowledge that I have received via email copies of the Borough's Drug, Motor Vehicle Fleet and Personnel Policies and Procedure Manual. I agree to read them thoroughly. I agree that if I do not understand any portion, I will seek clarification from my supervisor, the Mayor of the Borough Administrator. I understand that the Borough is an "at will" employer and consistent with applicable Federal and State Law including the New Jersey Civil Service Act, as well as applicable bargaining unit agreements, employment with the Borough is not for a fixed term or definite period and may be terminated at the will of either party, with or without cause, and without prior notice. No supervisor or other representative has the authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the above. I understand that these manuals state the Borough's policies in effect on the date of publication. I understand that nothing contained in these manuals may be construed as creating a promise of future benefits or a binding contract with the Borough for benefits or for any other purposes. I also understand that these manuals are continually evaluated and may be amended, modified or terminated at any time.

Please sign & date to confirm receipt.

Name: _____

Department & Title: _____

Print Name: _____

Signature: _____

Date: _____

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type | GROUP ID: BOROUGHOFA | GROUP POLICY #: 000860048045 | Billing Division or Location: 243372

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Borough of Fairview			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:		
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $_____		Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Basic Group Life ☒Yes ☐No*	$	Employer Paid

C. Beneficiary Information (Complete ONLY for Life/AD&D or Accident with AD&D)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Signature: Date:

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION

1711 Route 34 South • Wall Township, New Jersey 07727-3934
Telephone: (732) 798-8137 • (800) 852-0137

PHYSICAL EXAMINATION GUIDELINES

VALID FOR ONE (1) CALENDAR YEAR FROM THE DATE OF THE PHYSICAL

1. AGE: Must be at least 18 years of age and not older than 57 years of age.
2. EYES: Must be 20/50 corrected, monocular vision permitted (with glasses, contacts, or surgical procedures).
3. HEARING: Loss of hearing acuity so as to be unable to perceive sounds within normal voice range with or without hearing aid.
4. NOSE: Any significant nasal obstruction to free breathing not subject to correction by surgery.
5. MOUTH: Conditions which impair the ability to communicate.
6. NECK: Problems resulting from (a) Goiter; (b) Limited range of motion, which prohibits turning, extension or free movement of the neck; (c) Tracheotomy – existing openings at the lower portion of the neck connecting the windpipe to the outside environment for the purpose of easy breathing.
7. PULMONARY: Problems resulting from (a) Loss or removal of a lung; (b) Any pulmonary disorder which would limit the applicant's ability to perform; (c) Pulmonary Function Test below normal; (d) Chronic Obstructive Pulmonary Disease/Asthma.
8. CARDIO PULMONARY SYSTEM: Problems resulting from Heart Disease or Cardiomegaly.
9. PERIPHERAL VASCULAR SYSTEM: Problems resulting from (a) Varicose veins; (b) Aneurysms; (c) Lymphedema; (d) Thrombophlebitis; (e) Arteriosclerosis Obliterans; (f) Buerger's Disease; (g) Raynaud's Disease; (h) Arterio-Venous Fistula; (i) High Blood Pressure, not able to be corrected by medication. Acceptable blood pressure reading should be as follows (a) Systolic not higher than 140 but not lower than 80; (b) Diastolic maximum should be 100 mmhg and minimum 50 mmhg.
10. ABDOMEN: Problems resulting from (a) Organomegaly; (b) Signs of tenderness in an area; (c) Presence of masses such as hernias of various types.
11. GENITOURINARY SYSTEM: Problems arising from (a) Presence of abnormal masses; (b) Abnormal discharges from any of the orifices; (c) Active venereal Diseases; (d) Parasitic diseases; (e) Varicocele and Varices; (f) Hydrocele.
12. MUSCOLO-SKELETAL SYSTEM: Problems arising from (a) Congenital malformation; (b) Limitation of Motion; (c) Weakness; (d) Impairment or absence of one or more of the digits on either or both hands; (e) Impairment of function of the hands; (f) Missing toes if it interferes with ambulation; (g) Deformities of the spine, pelvis or extremities.
13. OTHERS: Problems arising from (a) Disqualification for psychiatric conditions must be determined by local agencies; (b) Allergic conditions which are chronic and incapacitating; (c) Severe Anemia; (d) Active Peptic Ulcer; (e) Diabetes; (f) History of epilepsy or seizures other than documented febrile convulsions in childhood; (g) Alcoholism or drug addiction; (h) Removal of vital organs; (i) Any other condition not listed above which would render the applicant incapable of performing their duties as a firefighter.

THESE MEDICAL GUIDELINES ARE TO BE FOLLOWED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT LICENSED IN THE STATE OF NEW JERSEY WHEN EXAMINING AN APPLICANT FOR MEMBERSHIP. ANY ABNORMAL FINDINGS MUST BE EXPLAINED IN THE REMARKS SECTION OF THE APPLICATION. ALL SECTIONS OF THE PHYSICAL MUST BE COMPLETELY AND PROPERLY FILLED OUT OR THE APPLICATION WILL BE RETURNED.

NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION

1711 Route 34 South • Wall Township, New Jersey 07727-3934
Telephone: (732) 798-8137 • (800) 852-0137

THIS NOTICE IS FOR YOUR INFORMATION.
Privacy Notice for our (Potential) Members – Please review it carefully

The New Jersey State Firefighter's Association (NJSFA) and each Officer and the Office Staff and all the Local Associations throughout the state strongly believe in protecting the confidentiality and security of the information we receive about you. This notice refers separately to the New Jersey State Firefighter's Association and each of the Local Associations by using the terms "us", "we", or "our". This notice describes our privacy policy and describes how we treat the information we receive about you.

Why We Receive and How We Use Information: We receive the initial information via a Membership Application and Physical Test Record, Form #100. The purpose of this application is to permit membership in our organization. This information is used to make sure the applicant is in compliance with New Jersey Statutes and our Compendium and By-Laws.

How We Receive Information: We get most of the information from you. The Secretary of the Local Relief Association forwards the application form to our office. The information that you give us when applying for membership generally provides the information we need. If we need to verify information or need additional information, we may obtain information from third parties such as physicians, hospitals, and other medical personnel. Information collected may relate to your health or other information stated on the application.

How We Protect Information: We treat information in a confidential manner. Our Officers, Advisory Committee and Office Staff are required to protect the confidentiality of information. We access information only when there is an appropriate reason to do so. We also have safeguards to protect information. All Officers, Advisory Committee members and Office Staff are required to comply with our policies.

Information Disclosure: We may disclose any information when we believe it necessary for the operation of our Association, or where disclosure is required by law. The application if in question may be forwarded to our Association Medical Doctor for evaluation. We do not make any other disclosures of information to other organizations or companies who may want to sell their products or services to you. We will not sell your name or application information to any organization, corporation, or catalog company.

Access to and Correction of Information: Generally, upon written request, we will make available your personal information for your review. Information received in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. This will be included under "Disclosure of Information."

AFTER COMPLETING YOUR PHYSICAL, SEPARATE THIS SHEET FROM THE APPLICATION AND PHYSICAL PAGE. PLEASE RETAIN THIS PAGE AND DO NOT RETURN IT TO YOUR LOCAL ASSOCIATION OR TO THE STATE OFFICE.

ONCE COMPLETED, RETURN THE ATTACHED APPLICATION/PHYSICAL TO YOUR LOCAL RELIEF ASSOCIATION SECRETARY.

ASSOCIATION #	COMPANY #	LINE #
FOR STATE OFFICE USE ONLY		

New Jersey State
Firefighter's Association
Application for Membership

Form 100 – REV 9/25

Date _____

_____ _____ _____ _____
Relief Association Name | Assoc. Number | Municipality | County

_____ _____
Fire Company Name | Fire Department Name

Applicant Name _____
First | Middle Initial | Last | Suffix

Home Address _____ _____
Street | Municipality | Zip Code | # of years

Date of Birth _____ Birth Place _____ SS # _____
(REQUIRED)

Applicant Phone Number _____ Applicant Email Address _____

Have you ever been charged with, pled guilty to, or been convicted of a crime involving and/or including arson: ☐Yes ☐No

Have you ever applied to be a member of the NJSFA? ☐Yes ☐No If yes, when _____ where _____

If you have a line number with another Relief Association: ☐ Stay with previous Association ☐ Move records to new Association

* **It is the Applicant's responsibility to notify their Local Relief Secretary of any address change throughout their career/membership.** *

I CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUTHFUL, COMPLETE AND ACCURATE. I AM AWARE THAT IF ANY OF THE INFORMATION PROVIDED ABOVE IS FALSE, I AM SUBJECT TO PUNISHMENT UNDER THE LAW.

Signature of Applicant (witnessed by a Notary Public): _____

State of New Jersey, County of _____,

On _____, 20_____ before me, _____, Notary Public in and for said county, personally appeared

_____, (signer) who has satisfactorily identified himself/herself as the signer to the above referenced document.

My Commission Expires: _____ _____ (Affix Notary Stamp Here)
Notary Public Signature

_____ _____
Signature of Relief Association Secretary | Signature of Chief of Department

Type of Firefighter the Applicant will be: ☐ Career (full time paid) ☐ Volunteer

Municipal/Fire District Approval: I hereby certify that this applicant was admitted to active membership in the Department and has been approved by the governing body of _____ on the ____ day of _____, 20_____.

Signature of Municipal Clerk/Board of Fire Commissioners: _____

A. Application portion should be completed by Applicant – Typed or Printed ONLY.
B. Application must have the Physical Test Record completed by a New Jersey Licensed Physician, Nurse Practitioner or Physician Assistant.
C. The completed Application and Physical Test Record must be returned to the Local Relief Secretary.
D. The Local Relief Secretary shall review the application for completeness, attain the proper signatures, and forward to the NJSFA State office.

The Applicant is not a member of the NJSFA until the completed application is received AND approved at the NJSFA State office. Email to Localreports@njsfa.com or fax to (732) 938-2580. Original hard copy no longer required.

Physical Test Record (Valid for one (1) year from the Date Examined)

To be filled out by a Physician, Nurse Practitioner or Physician Assistant that is licensed in the State of New Jersey. Once the Physical has been completed, this form must be returned to the Local Relief Association Secretary at the address listed below.

All sections of the Physical must be properly filled out. If improperly filled out or questions are left blank, the Physical will be returned for correction or completion. NO SECTION CAN BE LEFT BLANK.

Please Print

Name _____ _____
First Middle Initial Last Sex

☐ W. N. L.

Age _____ Height _____Ft. _____In. Weight _____ Lbs. Hearing: ☐ Other: _____ BP _____
(Numbers Please)

Eyesight: Left_____ Right _____ Both (Corrected) _____
(Numbers Please) (Monocular Vision Permitted)

Has Applicant any apparent disabilities in:

Facial _____ Pulmonary _____

Cardio Pulmonary_____ Vascular _____

Abdomen _____ Genitourinary _____

Musculo-Skeletal _____ Other _____

The Applicant is free of any, other than listed above, medical or physical conditions that would cause harm to him/her or any other firefighter(s): ☐ YES ☐ NO (If no, explain below)

Has Applicant ever suffered from injury? ☐ YES ☐ NO If so, what and when? _____

_____

_____

Remarks / or rejection is based on: _____

_____

_____

_____

I CERTIFY THAT AS A PRACTICING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT LICENSED IN THE STATE OF NEW JERSEY, THE APPLICANT IS FREE FROM ANY ACUTE OR CHRONIC DISEASE AND HAS NO PHYSICAL DEFECTS THAT WOULD HINDER HIS/HER ABILITY TO PERFORM THE DUTIES OF A FIREFIGHTER.

Date Examined _____ Examined at _____
Address of office

☐ Physician
☐ Nurse Practitioner
☐ Physician Ass't

_____ _____ _____
Examiner's Phone # Print Examiner's Name Signature of Examiner

* If a Nurse Practitioner or Physician Assistant, please indicate the name of the collaborating or supervising physician *

_____ _____
NPI Number Print Physician's Name

THE NEW JERSEY STATE FIREFIGHTER'S ASSOCIATION RESERVES THE RIGHT TO HAVE THIS APPLICATION REVIEWED BY A MEDICAL DOCTOR OF ITS CHOICE, INCLUDING A NEW PHYSICAL EXAMINATION IF NECESSARY.

This Application/Physical must be returned to the local Relief Association Secretary:

_____ _____ _____
Local Relief Secretary Name Address Zip code

FAIRVIEW FIRE DEPARTMENT
FIREMEN'S RELIEF ASSOCIATION
FAIRVIEW, BERGEN COUNTY, NEW JERSEY

DATE:_____

PROSPECTIVE MEMBER: _____

ADDRESS: _____

_____

PHONE: HOME_____ CELL_____

Dear Prospective Member:

Please find enclosed **NJ State Firemen's Association** membership application, (beige) and **Fairview Fire Department** membership application (white).. Fully complete **BOTH** applications and return to the President of the Fire Company you wish to join. The Fire Company President will be responsible to return the applications to the Local Relief Secretary.

Steps for completing application process:

1. COMPLETE NJ STATE FIREMEN'S APPLICATION ____
2. COMPLETE FAIRVIEW FIRE DEPT APPLICATION ____
3. COMPLETE PHYSICAL (rear of applications)
   Fire Dept. Physician; Holy Name Hospital Occupational Health. See Borough Clerk at Borough Hall ____
4. HAVE BOTH APPLICATIONS NOTORIZED ____
   (Borough Clerk, at Borough Hall)
5. FINGER PRINT & CRIMINAL HISTORY CHECK ____
   Fairview Police Detective Bureau 201-943-2100
6. Pre-Appointment Drug Testing as required by
   Borough Policy. See Borough Clerk at Borough Hall ____
7. Additional Borough Policy Review
   See Borough Clerk at Borough Hall ____

APPLICATIONS RECEIVED BY LOCAL RELIEF SECRETARY

LOCAL RELIEF SECRETARY SIGNATURE:_____

DATE:_____

FAIRVIEW VOLUNTEER FIRE DEPARTMENT
MEMBERSHIP APPLICATION

Please Print!

Fairview Fire Department
Fairview, NJ 07022

Name _____
First Initial Last

Address _____
Street Town Zip Code

Birthdate _____ Birthplace _____ S.S.# _____

Present Residence _____ For _____ Years

Regular Occupation _____

Employer _____

Employer Phone # _____

Have You Ever Been a Firefighter? _____ Yes _____ No

If so, when _____ Where _____

Home Phone # _____

Do you have a valid New Jersey Drivers License? _____ Yes _____ No

Driver License # _____

Have you ever been convicted of any criminal offense? _____ Yes _____ No

_____
Signature of Applicant

STATE OF NEW JERSEY COUNTY OF _____ **SS:**
_____ being duly sworn doth depose and says that the above statements are true to the best of his/her knowledge.
Sworn before me this _____ day of _____ 20__

_____
Signature of Notary Public

NOTICE TO THE APPLICANT

According to the Records and Identification Section of the New Jersey State Police, Volunteer Fire Departments continue to remain among the group of organizations that are eligible to request computerized Criminal History (CCH) checks of prospective volunteers from the State Bureau of Identification (SBI). By signing this application the prospective member agrees to be fingerprinted to a CCH check pursuant to N.J.S.A.53:1-20.6 and N.J.S.A. 13:591.1 et seq.

MUNICIPAL APPROVAL

We certify that the this applicant was admitted to active membership in the Fairview Fire Department and has been approved by the Governing body of the Borough of Fairview.

On this _____ day of _____ in the Year _____ A.D.

_____ _____
Signature of Mayor Signature of Fire Commissioner

_____ _____
Signature of Municipal Clerk Signature of Fire Chief

PHYSICAL TEST RECORD

To be filed out by a licensed physician in the State of New Jersey and channeled accordingly to the directions specified on the front of the application. All sections must be properly filled out or the application will be returned.

Please Print!

Name _____
First Initial Last

Age_____Height_____(ft.)_____(in.) Weight_____lbs.

Eyesight_____Hearing_____Blood Pressure_____

Has Applicant any apparent disabilities in:

Heart_____ Lungs_____

Joints_____ Veins_____

Feed and legs_____ Hands and arms_____

Spine_____ Hernia_____

Has Applicant ever suffered from injury? _____Yes _____No if so,

When_____ Describe_____

_____

Has Applicant ever suffered from dizziness of fainting spells? _____Yes _____No

Use of Narcotics? _____Yes _____No Describe_____0

Remarks_____

_____

I certify that as a practicing physician in the State of New Jersey the Applicant is free from any acute or chronic disease and has no physical defects.

Rejection is based on the following_____

_____

Date examined_____ Examined at_____
Address of Office

_____
Signature of Physician