Rockland County
Ed Day, Rockland County Executive

OFFICE OF FIRE AND EMERGENCY SERVICES
Fire Training Center, 35 Firemen's Memorial Drive
Pomona, New York 10970
Phone: (845) 364-8800 Fax: (845) 364-8961

Christopher G Kear
Director

Rockland County Hazardous Materials Team
Application For Membership

Prior to summitting, please make sure that the following are included with your Hazardous Materials Team application:

Application Form ☐

Letter of Recommendation ☐

Emergency Contact Form ☐

Background Check Form ☐

Copy of Drivers' License ☐

Copies of Training Certificates ☐

Copy of Physical (Int. or Ext.) ☐

Copy of Fit Test ☐

Received By:

Date Received: Click or tap to enter a date.

Hazardous Materials Applicant Application

Date:

Personal Information:

Name:

Street:

City: State: Zip:

Home #:

Cell #:

Email Address:

Date of Birth:

Emergency Service Organization:

Contact at Organization:

How Long as a Member:

Apparatus Driver: Yes ☐ No ☐

Interior Firefighter: Yes ☐ No ☐

Hazardous Materials Training Level(s):

Awareness: Yes ☐ No ☐

Operations: Yes ☐ No ☐

Technician: Yes ☐ No ☐

Technician Modules (since 2017): 1 ☐ 2 ☐ 3 ☐

HazMat Incident Command: Yes ☐ No ☐

Other Pertinent/Related Training:

ROCKLAND COUNTY HAZARDOUS MATERIALS TEAM

EMERGENCY CONTACT FORM

Date:

Team Member Name:

Home Address:

Home Number: Work Number:

Cell Number: Carrier:

E-Mail Address:

Primary Emergency Contact:

Name:

Home Number:

Cell Number:

Secondary Emergency Contact:

Name:

Home Number:

Cell Number:

Other Information:

Date of Birth: Blood Type:
Personal Physician: Phone Number:

Other Physician: Phone Number:

Allergies:

PERMISSION FOR BACKGROUND CHECK

I hereby give permission for the Police to do a background check on me.

Name: _____ **Signature:** _____

Date: _____

ROCKLAND COUNTY HAZARDOUS MATERIAL RESPONSE TEAM

35 Firemen's Memorial Drive Pomona, NY 10970

RCHMRT MEMBER MEDICAL REPORT
YEAR 20____

RCHMRT MEMBER: _____
FIRE DEPT/ORG.: _____
PHYSICIAN: _____

The above Hazardous Material Response Team member is medically qualified for the following category/categories:

Interior_____
Exterior: _____
Safety Officer/Fire Police: _____
Administrative____
Mask Fit: _____
Date of Physical _____

I certify the above to be true to the best of my knowledge.

Chief:
Print Name: _____
Sign Name: _____

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BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐ _____ **Policyholder** _____ **Policy Number** _____
☐ _____ **Policyholder** _____ **Policy Number** _____
☐ _____ **Policyholder** _____ **Policy Number** _____
☐ _____ **Policyholder** _____ **Policy Number** _____
☐ **Other** _____
☐ **Other** _____

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Date of Membership:**	**Social Security Number:** / /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class ☐ **Mark if additional beneficiaries are listed on a separate paper and attached.** **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class **(Name, address, phone number and/or email address of beneficiaries)**	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your 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.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	Relationship to Insured	Percent
One Beneficiary of a class Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

* 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.