

ELEPHANT BUTTE FIRE & EMS

Application for Probationary Membership

Please PRINT all information. Answer all questions to the best of your knowledge. ALL answers will be verified.

PERSONAL INFORMATION

Name _____
Date of Birth _____ (last) / _____ (first) / _____ (mi)
Drivers License # _____ Check if (CDL ___) or (E class ___)
Permanent Address _____
(Number & St.) (City) (State) (Zip)
Previous Address _____
If less than 3 yrs. (Number & St.) (City) (State) (Zip)
Telephone #: Home _____ Cell _____ Work _____
Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Spouse Name _____
Number of Dependents _____ Number of Children _____
How Long Have You Lived in the Elephant Butte Area? _____

EMPLOYMENT

Present Employer _____
Employer's Address _____
Employer's Telephone # _____ Position _____
Normal Working Hours _____
(Days of Week) (#hrs. of day) (Start Finish Times)
Previous Employer _____
If Less Than 3 Yrs. _____

EDUCATION

High School _____ Location _____
(Name) (City) (State)
College _____ Location _____
(Name) (City) (State)
List Any Previous Fire or EMS Training or Attach Copies of Certificates*NOTE: Copies will be required upon acceptance of membership.
Check All Areas of Interest: Medical ___ Rescue ___ Fire ___

CRIMINAL HISTORY / DPS Driving Record and Background Check

Have you ever been Convicted of a DWI? Yes ___ No ___ If Yes, Date(s) _____
Have you ever been Convicted of a Misdemeanor? Yes ___ No ___ If Yes, Date(s) _____
Have you ever been Convicted of a Felony? Yes ___ No ___ If Yes, Date(s) _____
If any question above was answered 'Yes', Please explain Charges, Probationary Status, etc. below:

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Telephone # _____

I hereby affirm that the above information is true and accurate to the best of my knowledge. I understand that Elephant Butte Fire & EMS may verify all information. Any false information may lead to my removal from this department.

Signature: _____ Date _____

Office Use Only: Probationary Term Beginning _____ Sponsor _____

ELEPHANT BUTTE FIRE DEPARTMENT

***MEMBER EMERGENCY CONTACT
INFORMATION***

MEMBER NAME: _____

ADDRESS: _____

PHONE: _____

CELL NUMBER: _____

IN CASE OF EMERGENCY CONTACT:

NAME: _____

PHONE NUMBERS: _____

ADDRESS: _____

NAME: _____

PHONE NUMBERS: _____



**CITY OF
ELEPHANT BUTTE FIRE / EMS DEPARTMENT**

307 Rock Canyon Rd.
P.O. Box 1582
Elephant Butte N.M 87935
Office: 575-744-5000
Fax: 575-744-4493
Cell: 575-740-4638

Date _____

I, _____, do hereby grant authorization to the Elephant Butte Fire & EMS Department or the City of Elephant Butte to perform a criminal background check and/or check of my driving record. This authorization will remain in effect until such time that a written revocation from myself is received by the Department/City Officers. In giving this authorization, I hereby release the Elephant Butte Fire & EMS Department and/or the City of Elephant Butte from any and all actions resulting from my records. A photocopy of this letter may be used in lieu of the original to obtain these records.

Driver's License Number _____

Date of Birth _____

Social Security Number (Optional) _____

(Printed Name)

(Witness)

(Signature)

(Witness)



PUBLIC EMPLOYEES RETIREMENT ASSOCIATION OF NEW MEXICO

PUBLIC EMPLOYEES RETIREMENT BOARD

P.O. Box 2123, Santa Fe, New Mexico 87504-2123

(505) 476-9401 fax (505) 476-9300 voice

www.pera.state.nm.us

MEMBER ENROLLMENT FOR VOLUNTEER FIREFIGHTERS

Instructions: Please print or type in dark ink. The original of this form must be completed in its entirety and returned to PERA for processing. Required fields are in **BOLD ITALICS**

SECTION A – MEMBER INFORMATION		PLEASE PRINT CLEARLY	
SOCIAL SECURITY NUMBER		PERA ID NUMBER	
FIRST NAME	MI	LAST NAME	
Previous Last Name		Previous First Name	
ADDRESS TYPE	<input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY <input type="checkbox"/> MAILING	HOME TELEPHONE NO.	
ADDRESS		BUSINESS TELEPHONE NO.	
CITY	STATE	ZIP	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH	CITY OF BIRTH	STATE OF BIRTH	
HAVE YOU EVER BEEN A PERA MEMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		EMAIL ADDRESS	
ARE YOU OR HAVE YOU BEEN A MEMBER OF ANY OTHER NEW MEXICO RETIREMENT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, PLEASE CHECK WHICH PLAN(S): <input type="checkbox"/> JUDICIAL <input type="checkbox"/> MAGISTRATE <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> VOLUNTEER FIREFIGHTER <input type="checkbox"/> LEGISLATIVE			
ARE YOU RECEIVING A PENSION FROM ANY OF THESE PLANS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
MARITAL INFORMATION			
CURRENT MARITAL STATUS (Check One)			
<input type="checkbox"/> NEVER BEEN MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
SPOUSE'S NAME		SSN	DATE OF BIRTH (mm/dd/ccyy)
MEMBER CERTIFICATION			
I hereby declare that all the above information is true and complete to the best of my knowledge.			
SIGNATURE OF VOLUNTEER FIREFIGHTER			DATE
SECTION B - VOLUNTEER FIREFIGHTER DEPARTMENT CERTIFICATION			
MUST BE COMPLETED BY THE FIRE CHIEF			
Please copy the completed application for the district's file and for the volunteer. Return only the original form to PERA immediately upon completion.			
NAME OF VOLUNTEER FIREFIGHTER DEPARTMENT			
PERA FIREFIGHTER DEPARTMENT NUMBER		START DATE	
I certify that the above-named individual is a volunteer of this department as of the above date.			
SIGNATURE OF CHIEF		DATE OF SIGNATURE (mm/dd/ccyy)	
TITLE		BUSINESS TELEPHONE NO.	

Beneficiary Designation for Accident & Sickness Policy

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

Name of Organization _____

Member's/Employee's Name _____

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

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

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

Primary

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

Contingent

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

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made to my estate. 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.

Volunteer Firemen's Insurance Services, Inc.®

Beneficiary Designation for Accident & Sickness Policy

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

Name of Organization _____

Member's/Employee's Name _____

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

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

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

Primary

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

Contingent

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

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

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