



**EMPLOYMENT**

List most recent employment first.

Company		Phone
Address		
Position		Supervisor
From	To	Reason for Leaving
Company		Phone
Address		
Position		Supervisor
From	To	Reason for Leaving
Company		Phone
Address		
Position		Supervisor
From	To	Reason for Leaving

**EXPERIENCE**

List all prior experience with volunteer fire, EMS, and other public safety organizations.

Agency		Phone
Address		
Position		Chief
From	To	Reason for Leaving
Agency		Phone
Address		
Position		Chief
From	To	Reason for Leaving
If you have additional experience, please attach.		

**REFERENCES**

List three references. Do not include relatives or employers.

Full Name		Phone
Address		Relationship
Full Name		Phone
Address		Relationship
Full Name		Phone
Address		Relationship

**STATEMENT**

I hereby certify that every statement I have made on this application and supporting documents is true and complete. I understand that any false information or omission may disqualify me from further consideration for membership and may result in my immediate discharge if discovered at a later date. I understand that if this application is incomplete, it will not be processed.

I authorize the Spotsylvania County Department of Fire, Rescue & Emergency Management and this volunteer agency to investigate, without liability, all statements contained in this application and supporting materials. I also authorize references, employers, public safety agencies, and others, without liability, to make full response to any inquiries in connection with this application.

I understand that the use of illegal drugs is strictly prohibited and grounds for immediate termination. The use of alcohol or misuse of prescription drugs prior to or during duty is a serious violation punishable up to and including termination. I understand that I may be subject to random drug testing at any time.

My signature authorizes drug screening, investigative reports, criminal history and driving record checks, reference checks, and physical examination if required.

**Signature****Date**

# SPOTSYLVANIA VOLUNTEER FIRE DEPARTMENT

## Attachment – Applicant Background Investigation

Please provide the following information and authorization to complete a mandatory applicant background investigation.

INFORMATION		
Last Name	First	Middle
Date of Birth	Soc. Sec. No.	Gender
Driver's License Number		State

AUTHORIZATION	
<p>I authorize the Spotsylvania County Department of Fire, Rescue &amp; Emergency Management and this volunteer agency to investigate, without liability, all statements contained in the membership application and supporting materials.</p> <p>I also authorize references, employers, public safety agencies, and others, without liability, to make full response to any inquiries in connection with this application.</p> <p>My signature authorizes drug screening, investigative reports, criminal history and driving record checks, reference checks, and physical examination if required.</p>	
<b>Signature</b>	<b>Date</b>

Please complete the yellow highlighted sections of the attached Virginia DMV Form CRD 93.

**Purpose:** Use this form to request information from DMV records.

**Instructions:** Type or print clearly.

REQUESTER INFORMATION		
REQUESTER FULL NAME (last, first, mi, suffix)		FEDERAL TAX ID OR SOCIAL SECURITY NUMBER*
ORGANIZATIONAL AFFILIATION (if any)	TELEPHONE NUMBER	USE AGREEMENT NUMBER (if applicable)
STREET ADDRESS		ACCESS CODE (if applicable)
CITY	STATE	ZIP CODE
REASON FOR REQUEST (be specific)		

SUBJECT INFORMATION		
If you are requesting driving record information, the subject will be the person you are requesting information on. If you are requesting vehicle information, the subject will be the vehicle owner (if available), otherwise you do not need to complete this section.		
SUBJECT FULL NAME (last, first, mi, suffix)		<input type="checkbox"/> CHECK TO INDICATE SUBJECT NAME AND ADDRESS IS THE SAME AS THE REQUESTER ABOVE.
STREET ADDRESS		
CITY	STATE	ZIP CODE

INFORMATION REQUESTED		
Check one or more boxes below to indicate the type of information you wish to receive. All data fields must be completed for Driving Record Information, Vehicle Information and Decedent Photo Requests. For Police Crash Reports provide as much information as possible.		
<input type="checkbox"/> <b>DRIVING RECORD INFORMATION (Includes license history and conviction data) (complete SUBJECT INFORMATION above)</b>		
SUBJECT DRIVER LICENSE NUMBER		OR SUBJECT BIRTH DATE (mm/dd/yyyy)
An authorization from the subject is required for employers and others not authorized by Virginia code. I authorize the Department of Motor Vehicles to furnish, for this one time only, information pertaining to my driving record to the requester identified above.		
SUBJECT SIGNATURE		DATE (mm/dd/yyyy)
<input type="checkbox"/> <b>VEHICLE INFORMATION (Includes vehicle description and registration data) (complete SUBJECT INFORMATION above)</b>		
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE MAKE	VEHICLE YEAR
<input type="checkbox"/> <b>POLICE CRASH REPORT</b>		
Check one or more boxes to indicate your involvement in the crash:		
<input type="checkbox"/> I was a DRIVER <input type="checkbox"/> I was a PASSENGER <input type="checkbox"/> I am a VEHICLE OWNER <input type="checkbox"/> I am the OWNER of property involved in the accident <input type="checkbox"/> I legally REPRESENT an involved person <input type="checkbox"/> I was injured <input type="checkbox"/> OTHER (explain) _____ <input type="checkbox"/> I was <b>NOT</b> involved in the accident <b>AND</b> I do not legally represent an involved person _____ <input type="checkbox"/> I am an authorized representative of any insurance carrier reasonably anticipating exposure to civil liability as a consequence of the accident or to which the person has applied for issuance or renewal of a policy of automobile insurance		
<b>IMPORTANT NOTE:</b> The Department may only release a full accident report to a person involved in the accident, or their legal or personal representative, in accordance with Virginia Code § 46.2-380. All other requesters are entitled to receive only the name and addresses of the drivers, the owners of the vehicles involved, the injured persons, the witnesses, and one investigating officer, in accordance with Virginia Code § 46.2-379.		
CRASH DATE (mm/dd/yyyy)	TIME OF CRASH	CRASH LOCATION (highway or street name)
CITY/COUNTY/TOWN WHERE CRASH OCCURRED	DRIVER FULL NAME (last, first, mi, suffix)	DRIVER LICENSE NUMBER
1. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix)		2. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix)
3. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix)		4. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix)

**INFORMATION REQUESTED (continued)**

**DECEDENT PHOTO REQUEST** (requester *may* need to provide proof of death, i.e. copy of death certificate, executor papers, etc.)

DECEDENT FULL NAME (last, first, mi, suffix)		DECEDENT DMV CUSTOMER NUMBER	
DECEDENT BIRTH DATE (mm/dd/yyyy)	Requester's relationship to decedent (check one):	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Executor <input type="checkbox"/> Administrator

**CERTIFICATION**

I understand that it is unlawful to use information provided by DMV for any purpose other than the one stated. I certify that the information I have requested with this form will be used only for the stated purpose.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and understand that knowingly making a false statement or representation on this form is a criminal violation.

I agree that the information I obtain in response to my request is considered privileged and confidential. I agree that such information is subject to the restrictions upon use and dissemination imposed by (1) the Federal Drivers Privacy Protection Act (18 USC § 2721 et seq.), (2) the Government Data Collection and Dissemination Practices Act (Va. Code § 2.2-3800 et seq.), (3) the provisions of Va. Code §§ 46.2-208 through 210, 46.2-212, and 58.1-3, and (4) any successor rules, regulations, or guidelines adopted by DMV with regard to disclosure or dissemination of any information obtained from DMV records or files, and I agree to comply with such restrictions and understand that any violation may result in damages, civil penalties, criminal penalties or other relief permitted pursuant to Virginia law.

REQUESTER SIGNATURE	DATE (mm/dd/yyyy)
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**OTHER INFORMATION (Be specific)**

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**DMV CUSTOMER SERVICE CENTER USE ONLY**

Proof of Requester's Identification

Valid Driver's License Number \_\_\_\_\_

Other Photo Identification \_\_\_\_\_

Proof of Requester's Organization Affiliation

Request on Organization Letterhead Stationery

Business Card from Organization

Law Enforcement Badge Number \_\_\_\_\_

Other \_\_\_\_\_

If referred to Headquarters to Fill Request, Complete:

CSR Name \_\_\_\_\_

CSC Name (not CSC number) \_\_\_\_\_

Remarks/CSR Stamp

Fee Charged

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