To: Fire Academy Applicants

From: Mark Yokoyama, Dean of Public Safety
Subject: Class 100 Fire Academy Application Process

Class 100 of the Rio Hondo Firefighter I & II Basic Academy is a full-time academy. The academy class meets 5 days a week from 0600 to 1800, Monday through Friday. **Class 100 is scheduled to begin on Monday, January 30th, 2023, and graduates on Thursday, May 25th, 2023.**

Applicants are advised that Prior to **January 30, 2023** they must have:

- Completed the six (6) fire technology core classes,
- Passed EMT with at least a “B” grade or possess a current EMT-B Card
- Passed FTEC 044 or equivalent (Physical Fitness & Ability for the Firefighter)

**Applications must be submitted** with unofficial transcripts, medical examination record and supporting documentation, in person, **ONLY on Tuesday November 15th (11 am – 6 pm) or Wednesday November 16th (9 am – 2 pm).** At each of these sessions, vehicles will **LINE UP** facing North against the curb in front of the Fire Academy facility. Once in line, **remain in your vehicle until summoned**, and then you may enter the application drop off site.

The Rio Hondo Fire Academy is located at **11400 Greenstone Avenue, Santa Fe Springs, 90670.**

All Fire Academy candidates are required to take the Biddle Physical Abilities Test on **Saturday, December 17th**, even if you have taken it before. Candidates who do not take the agility test on this date will be removed from the application process.

A letter will be sent by email to all accepted candidates by **December 21, 2022.** This letter will advise you on the process for registration for the class and other crucial events and dates.

For the required medical examination, applicants will have to use their own Doctor or Health Center. The Rio Hondo College Student Health Services is not able to provide this service.

If you are unable to submit your application on either of the above dates, contact counselor Diana Valladares (DValladares@riohondo.edu).
## FIREFIGHTER I & II ACADEMY APPLICATION & CHECKLIST

Last Name __________________________ First Name __________________________ M.I. __________

Address: ____________________________________________________________

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Home Phone: (_____) ________________________  Cell Phone: (_____) ______________________

Birthday: _____ / _____ / _____  Email: ________________________________

- [ ] Male    - [ ] Female    - [ ] Nonbinary    - [ ] RHC ID # ________________________________
- [ ] Pre-Service  - [ ] In-Service / Sponsored by Agency: ________________________________

Signature: ________________________________  Date ________________________________

Items required on separate sheets of paper: (Copies will not be made on site)

- [ ] Unofficial Transcripts of Fire Technology classes
- [ ] Current EMT-B Card or EMT-B Course with at least a “B”
- [ ] Course Verification (Completed by Counselor Valladares on the day you drop off application)
- [ ] Physical Examination Form (2 pages) including copies of Immunization Records
- [ ] Medical Insurance Verification Form
  - [ ] If you have medical insurance, a copy of your insurance card
- [ ] Copy of your Driver’s License
  
  Other documents potentially needed:

- [ ] Coursework-in-Progress Form (only Fire Technology classes that are still pending a final grade)
- [ ] Sponsorship Form (Only if you are an in-service applicant)
BASIC FIRE ACADEMY

IN-SERVICE AND SPONSORSHIP VERIFICATION

I hereby certify that ________________________________ is a bonafide:

IN-SERVICE CADET

☐ Fully paid member of a governmental or industrial fire protection or fire prevention agency. I also certify that this individual will be provided with worker’s compensation insurance by my agency for any injury suffered during the course of the academy.

☐ Current EMT Certification or Completed a Certified EMT-1 course with at least a “B”

SPONSORED CADET

☐ Auxiliary member of a department which:

   Has completed:
   ☐ Current EMT Certification or Certified EMT-B course with at least a “B”

   ☐ Rio Hondo College Fire Technology Core Courses with a grade “C” or better
      ☐ FTEC101  ☐ FTEC102  ☐ FTEC103  ☐ FTEC104  ☐ FTEC105  ☐ FTEC106

   ☐ FTEC 044

Signature: __________________________________________________________________ Date: __________________________________________________________________

Fire Chief

Fire Chief’s Printed Name: ____________________________________________________________________________________________

Department: ___________________________ Phone Number: ( ) ___________________________
**COURSEWORK-IN-PROGRESS VERIFICATION**

Use ONE form per college. Photocopy additional forms as needed.

Date: ______________________

Last Name: ______________________  First: ______________________

Birthday: __ __ / __ __ / __ __  Student ID #: __ __ __ - __ __ __ __ __

Name of College: ______________________

Semester:  ☐ Fall  ☐ Spring  ☐ Summer  Year: __________

**STUDENT:** Identify the course #, title and units on the form. Please have your Fire Technology instructors verify your current progress by indicating your current grade and signing below. Email your online instructors asking them to send your progress directly to you via email. Print a copy of the email and attach it to this form.

**INSTRUCTOR:** Tentative grades are needed for the above named student who is applying for the Rio Hondo College Fire Academy. For online courses, please email coursework-in-progress directly to student for processing.

<table>
<thead>
<tr>
<th>Course #</th>
<th>Fire Technology (Pending Courses Only)</th>
<th>Current Grade</th>
<th>Instructor’s Name/Signature</th>
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<tbody>
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<td>A B C D F CR NC</td>
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<td>A B C D F CR NC</td>
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</table>
RECORD OF MEDICAL HISTORY AND PHYSICAL EXAMINATION
(To be completed by student. Please use ink and print clearly.)

NAME: ___________________________________________ DATE: ________________________

PERMANENT ADDRESS: ________________________________________

Street ___________________________ City ______________________ State ______ Zip Code ___________

TELEPHONE: ___________________________ STUDENT ID: ______________________

DATE OF BIRTH: _______________ PLACE OF BIRTH: ________________________ SOCIAL SECURITY NO: ___________

HEALTH HISTORY
Check conditions you have had or now have. Show dates on non-chronic conditions.

☐ Allergies ☐ Convulsive Disorder ☐ Heart Trouble ☐ Rheumatic Fever
☐ Anemia ☐ Crohn’s Disease ☐ High Blood Pressure ☐ Seizures
☐ Arthritis ☐ Diabetes ☐ Impairment of Hearing ☐ Smoking Habits
☐ Asthma ☐ Dizziness ☐ Kidney Trouble ☐ Packs Daily: 1 2 3
☐ Back Pain ☐ Draining Ear ☐ Marked Fatigue ☐ Stomach Conditions
☐ Bladder Conditions ☐ Fainting ☐ Nervous Breakdown ☐ Thyroid Disease
☐ Bronchitis ☐ Gall Bladder Disease ☐ Other Blood Diseases ☐ Treatment for Alcoholism
☐ Cancer ☐ Headaches (Frequent) ☐ Palpitation ☐ Treatment for Drug Addiction
☐ Chicken Pox ☐ Headaches (Migraine) ☐ Pneumonia ☐ Ulcers

List any other illness you have had. (include dates) ________________________________________________________________

List medications. Prescribed: ___________________________________________ Over the counter taken regularly: _____________________________

Surgical Procedures. (Give date and nature) _____________________________

Severe Accidents, including fractures. (Give date and nature) _____________________________

Female Menstrual Disorders ____________________________________________

IMMUNIZATIONS: Indicate which vaccinations and immunizations you have had. (Give dates) (WRITTEN proof of immunization is required)

<table>
<thead>
<tr>
<th>MMR 1</th>
<th>MMR 2</th>
<th>Titer Results</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Hepatitis 1</th>
<th>Hepatitis 2</th>
<th>Hepatitis 3</th>
<th>Titer Results</th>
</tr>
</thead>
<tbody>
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</table>

<table>
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<tr>
<th>Varicella 1</th>
<th>Varicella 2</th>
<th>Titer Results</th>
<th>Tetanus Diphtheria Booster (within past 10 years)</th>
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TB Test Date: _______________ Reaction: ___________________________ If TB skin test is positive, a chest x-ray is required.

CHEST X-RAY RESULTS Date: ___________________________ RESULTS ___________________________

* Women should not receive the Rubella vaccine if they are pregnant or might become pregnant within 3 months. However, if you are vaccinated and then find out you were pregnant at the time, it should not be a cause for concern. Rubella vaccine has never been known to harm an unborn child.

FEMALE CLIENTS: NURSE: Patient counseled regarding importance of not becoming pregnant within 3 months of vaccination? ☐ Yes ☐ No

Send to see primary medical physician if pregnant. ☐ Yes ☐ No

Nurses Signature: ___________________________ Date: ________________

FAMILY MEDICAL HISTORY

<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
<th>BROTHERS</th>
<th>SISTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Place of Birth</td>
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<tr>
<td>Occupation</td>
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<td>State of Health</td>
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<td>Age</td>
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<tr>
<td>If Deceased, Cause of Death</td>
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</tbody>
</table>
LAST NAME: __________________________________________ FIRST NAME: __________________________________________

PHYSICAL EXAMINATION  (To be completed by Physician)

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Temperature</th>
<th>Pulse</th>
<th>Respiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
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<td>Ears</td>
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<tr>
<td>Eyes</td>
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<td>Throat</td>
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<tr>
<td>Teeth</td>
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<td>Neck</td>
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<tr>
<td>Chest / Lungs</td>
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<td>Heart: Before Exercise</td>
<td>After Exercise</td>
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<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td>Hernia</td>
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Pregnancy Test ☐ + ☐ - Female cadets must have a Urine Pregnancy Test.

Back Dorsal Spine

Extremities

Neurological

Recommendations:

<table>
<thead>
<tr>
<th>HEARING</th>
<th>VISION SCREENING</th>
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<tbody>
<tr>
<td>250</td>
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<tr>
<td>500</td>
<td></td>
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<tr>
<td>1000</td>
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<tr>
<td>Right</td>
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</tr>
<tr>
<td>Left</td>
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</tr>
</tbody>
</table>

Uncorrected

Corrected

Color Vision

Wears ☐ Glasses ☐ Contact Lenses

Examiner:

Date:

CHEM PANEL INCLUDES URINALYSIS: Date: ____________________________

This client has been examined and found physically acceptable for a Basic Fire Academy Training Program. ☐ YES ☐ NO

Examining Physician: ____________________________ Date: ____________________________

(Signature)

Provider Printed Name: ____________________________ Phone: ____________________________
INSURANCE VERIFICATION

Name: ___________________________________________  Home Phone: ________________

Address: ____________________________________________________________________________

Soc Security No.: __ __ __ - __ __ __ Student ID #: __ __ __ DOB: ____________ __ __ __ __ __

Do you have medical insurance?  ☐ Yes  ☐ No  (Note: Insurance is not necessary to enter the Fire Academy)

Is this insurance the ☐ Primary Insurance or ☐ Secondary Insurance?

Insurance Co: ___________________________________________  ☐ Individual  ☐ Group  ☐ HMO

Policy holder’s name: ___________________________________  Relationship: ________________

Policy No: ________________  Group No: ________________  Member No: ______________________

Ins. Co. Address: ________________________________________________________________

Does your place of employment provide this insurance?  ☐ Yes  ☐ No

If yes, Employer’s Name: _______________________________  Phone: _________________________

Address: ________________________________________________________________

Are you covered by any other medical insurance(s)?  ☐ Yes  ☐ No

Is this insurance the ☐ Primary Insurance or ☐ Secondary Insurance?

Insurance Co: ___________________________________________  ☐ Individual  ☐ Group  ☐ HMO

Policy holder’s name: ___________________________________  Relationship: ________________

Policy No: ________________  Group No: ________________  Member No: ______________________

Ins. Co. Address: ________________________________________________________________

Is this insurance the ☐ Primary Insurance or ☐ Secondary Insurance?

Insurance Co: ___________________________________________  ☐ Individual  ☐ Group  ☐ HMO

Policy holder’s name: ___________________________________  Relationship: ________________

Policy No: ________________  Group No: ________________  Member No: ______________________

Ins. Co. Address: ________________________________________________________________

I hereby certify that the foregoing answers I have designated to the stated questions are true, complete, and correct to the best of my knowledge.

_________________________________________  ____________________________
Signature                                      Date
QUESTIONNAIRE

Last Name: ________________________________ First: __________________________ M.I. _____

1. Were you accepted in a prior Academy class here or at another Fire Academy? □ Yes □ No
   If so, which class or which Academy? ____________________________

2. Have you ever served in the American Armed Forces? □ Yes □ No
   If so, what branch of service? ____________________________
   How long? _________
   What was your military specialty? ____________________________

3. Have you been a member of a Fire Explorer Post? □ Yes □ No
   If so, for what Fire Department ____________________________
   How long? _________

4. Do you have any fire service experience? □ Yes □ No
   If so, what kind? ____________________________
   How long? ______________