To: Fire Academy Applicants  
From: Kurt Norwood, RHC Fire Academy Director  

Subject: Class 102 Fire Academy Application Process  

Class 102 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 102 is scheduled to begin on Monday, January 29th 2024 and graduates on Thursday, May 23rd 2024.**

Applicants are advised that Prior to **January 29, 2024,** 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 Monday November 13th (11 am – 6 pm) or Wednesday November 15th (9 am – 2 pm). Tentatively, at 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. If this should change, applicants will be informed upon arrival.**

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 16th,** tentatively, 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 22, 2023, tentatively.** 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 or Urgent Care 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).
**RIO HONDO COMMUNITY COLLEGE DISTRICT**
Division of Public Safety - Fire Technology
11400 Greenstone Avenue • Santa Fe Springs • California • 90670
(562) 941-4082

**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: ( _____ ) ___________________________

Birthdate: _____ / _____ / _______ 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 (or equivalent) 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: ___________________________

Birthdate: ___ / ___ / ___ 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>
</tr>
</thead>
<tbody>
<tr>
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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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<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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</tbody>
</table>
**RIO HONDO COMMUNITY COLLEGE DISTRICT**  
Division of Public Safety - Fire Technology  
11400 Greenstone Avenue • Santa Fe Springs • California • 90670  
(562) 941-4082

**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: ____________________________  
PLACE OF BIRTH: ____________________________  
Zip Code: ____________________________  
**TELEPHONE:** ____________________________  
**STUDENT ID:** ____________________________

**DATE 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>Vaccine Type</th>
<th>Date</th>
<th>Titer Results</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis 3</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Titer Results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Titer Results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella 2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Varicella 3</td>
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<td>Titer Results</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Varicella 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Titer Results</td>
<td></td>
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</tr>
</tbody>
</table>

**TB TEST**  
Date: ____________________________  
Reaction: ____________________________  
If TB skin test is positive, a chest x-ray is required.  
CHEST X-RAY RESULTS Date: ____________________________

*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>
</tr>
<tr>
<td>Place of Birth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State of Health</td>
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<td></td>
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<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>If Deceased, Cause of Death</td>
<td></td>
<td></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>
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</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Ears</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Throat</td>
<td></td>
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</tr>
<tr>
<td>Teeth</td>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest / Lungs</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Heart: Before Exercise</td>
<td>After Exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Hernia</td>
<td></td>
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</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
</tr>
<tr>
<td>250</td>
<td></td>
</tr>
<tr>
<td>500</td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td></td>
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<tr>
<td>2000</td>
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<tr>
<td>4000</td>
<td></td>
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<tr>
<td>6000</td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
</tr>
</tbody>
</table>

Uncorrected

Corrected

Color Vision

Wears ☐ Glasses ☐ Contact Lenses

Examiner: ___________________________

Date: ___________________________

Audio metrist: ___________________________

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? __________________________