



Marion Fire District  
PO Box 939  
Marion MT 59925  
Office: 406.854.2828  
www.marionfd.org

### Marion Fire District Application

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Physical Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Phone # Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

Driver License Number: \_\_\_\_\_ State: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Residence History: (List all the places you have lived in the last five years)

Dates	Address	City	State	Zip	Landlord

1. Are you legally authorized to work in the U.S.? YES \_\_\_\_\_ NO \_\_\_\_\_

2. If selected, can you provide proof that you are at least 18 years of age?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Do you have any relatives on the Fire Department? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, who? \_\_\_\_\_

Employment History: (include the last five years starting with the most current)

Employment:

Present or Most Recent Employer: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Job Title: \_\_\_\_\_

Date Employed: \_\_\_\_\_

Total Years Employed: \_\_\_\_\_

Working Hours: \_\_\_\_\_

Specific Duties: \_\_\_\_\_

\_\_\_\_\_



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Emergency Service Experience: (List any Emergency Service Experience, Fire, EMS, etc.)

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Education and Training:

What is the last grade completed- Grade 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Masters \_\_\_ Doctorate \_\_\_

What college or university did you attend? (If applicable) \_\_\_\_\_

List any scholarships, academic honors, awards or special achievements:

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Personal References: (List three references of people not related to you)

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been convicted of a felony? (If yes, please explain)

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Have you ever been convicted of a misdemeanor or traffic offense? (Yes/No)

Date	Offense	County	Disposition

Medical Certifications:

EMP  EMT

List any endorsements: \_\_\_\_\_

**Please provide copies of the State and National EMT Cards and Healthcare Provider Card.**

I certify that the information on this application is true and correct to the best of my knowledge. Any falsehoods, misrepresentations, misstatements, or omissions on this application shall subject me to disqualification or dismissal.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Do Not Write Here: (Administrative Use Only)

Date Received: \_\_\_\_\_ Date Interviewed: \_\_\_\_\_

Comments:

Accepted? \_\_\_\_\_ Recommended probation to end: \_\_\_\_\_

Notes: