



# CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION



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## VOLUNTEER IN PREVENTION APPLICATION AND SERVICE AGREEMENT CAL FIRE-670

NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME PHONE	
ADDRESS			WORK PHONE	
CITY/TOWN		ZIP	EMAIL ADDRESS	
SOCIAL SECURITY NUMBER			DATE OF BIRTH	
DRIVER'S LICENSE NUMBER			VEHICLE LICENSE NUMBER	
HAIR	EYES	HEIGHT	WEIGHT	

IS THERE A SPECIFIC JOB OR AREA YOU MIGHT BE INTERESTED IN?  
(PLEASE CHECK ANY OF THE FOLLOWING AREAS OF INTEREST)

- |  |   |
|--|---|
| <input type="checkbox"/> SCHOOL PROGRAMS             | <input type="checkbox"/> HAM RADIO OPERATIONS     |
| <input type="checkbox"/> PUBLIC INFORMATION DISPLAYS | <input type="checkbox"/> FIRE SAFETY INSPECTIONS  |
| <input type="checkbox"/> COMPUTER/CLERICAL WORK      | <input type="checkbox"/> FIRE INFORMATION CENTERS |
| <input type="checkbox"/> OTHER (PLEASE LIST)         |   |

PLEASE LIST ANY SPECIAL SKILLS, TALENTS, OR HOBBIES.

PLEASE LIST YOUR CURRENT OR PREVIOUS OCCUPATIONS.

ARE YOU WILLING TO USE YOUR PRIVATE VEHICLE WHILE PERFORMING VOLUNTEER DUTIES?

- YES  NO

HOW DID YOU HEAR ABOUT THE VOLUNTEER IN PREVENTION PROGRAM?

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT:

YOUR SIGNATURE

DATE



CALIFORNIA DEPARTMENT OF FORESTRY  
AND FIRE PROTECTION



**INFORMATION WORKSHEET**

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NAME (PLEASE TYPE OR PRINT) \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**INTERESTS:**

School Programs: \_\_\_\_\_

Float Construction \_\_\_\_\_

County Fair \_\_\_\_\_

Office Work: \_\_\_\_\_

Exhibits: \_\_\_\_\_

Smokey Patrol: \_\_\_\_\_

Parades: \_\_\_\_\_

Fire Information: \_\_\_\_\_

Home Inspector: \_\_\_\_\_

Smokey Bear: \_\_\_\_\_

Other \_\_\_\_\_

Do you have a VIP uniform shirt? \_\_\_\_\_

Shoulder Patches? \_\_\_\_\_

Have you signed an I.D. Card? \_\_\_\_\_

How would you like your name listed on your nametag? \_\_\_\_\_

**For HAM Radio Operators:**

What is your Call Sign? \_\_\_\_\_

AVAILABILITY: Days: \_\_\_\_\_ Nights: \_\_\_\_\_ Weekends: \_\_\_\_\_

**CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION  
VOLUNTEER SERVICE AGREEMENT**

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**VOLUNTEER**

**SUPERVISOR**

NAME		NAME	
ADDRESS		ADDRESS	
TELEPHONE #	SOCIAL SECURITY #	TELEPHONE #	

Assigned by the above named supervisor, I \_\_\_\_\_ Will comply with all policies, procedures, rules, regulations, directives and instructions provided. I will conduct myself in accordance with those standards set forth for regular Department employees. I understand and agree to the following policies and conditions.

I will be covered under State Worker's Compensation.

I may use a State Vehicle, when directed, provided that I have a valid California Driver's License. I agree to participate in the State Defensive Driver Training Program at the earliest opportunity.

I may be reimbursed for use of my private vehicle, provided it is specifically directed, and provided that I have filed a certificate of insurance with the Department.

I may use State equipment and supplies, including safety equipment, when directed.

**OATH OF ALLEGIANCE**

\_\_\_\_\_ Do solemnly swear (or affirm) that I will support and defend the Constitution of the (Print Name) United States and the Constitution of the State of California against all enemies, foreign and domestic, that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California, that I take this obligation freely, without any mental reservation or purpose of evasion, and that I will well and faithfully discharge the duties upon which I am about to enter.

Taken and subscribed before me this \_\_\_\_\_ Day of \_\_\_\_\_

SIGNATURE OF EMPLOYEE	SIGNATURE OF AUTHORIZED OFFICIAL
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(TERMS OF THIS AGREEMENT ARE FOR 2 YEARS UNLESS EXTENDED) EXTENDED TO: \_\_\_\_\_

**I CERTIFICATION**

In accordance with State Policy (S.A.M. 0754) approval is requested to use privately owned vehicles to conduct official State business. I hereby certify that whenever I drive a privately owned vehicle on State business I will have a valid driver's license in my possession, all persons in the vehicle will wear safety belts and the vehicle shall always be:

1. Covered by liability insurance for the minimum amount prescribed by State law. (\$15,000 for personal injury to, death of one person; \$30,000 for injury to, or death to, two or more persons in one accident; \$5,000 property damage.)
2. Adequate for the work to be performed.
3. Equipped with safety belts in operating condition.
4. To the best of my knowledge, in safe mechanical condition as required by law.

I further certify that while using a privately owned vehicle on official State business, all accidents will be reported on form Std. 270 within 48 hours (S.A.M. 2541).

I understand that permission to drive a privately owned vehicle on State business is a privilege which may be suspended or revoked at any time.

DRIVER'S LICENSE NUMBER	STATE	EXPIRATION DATE
EMPLOYEES' SIGNATURE	PRINT NAME	DATE

**II APPROVAL**

Use of a privately owned vehicle on State business is approved.

SIGNATURE	TITLE	DATE
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**CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION  
PARENTAL CONSENT FORM**

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\_\_\_\_\_ Has my permission to participate in the

MINOR's NAME

California Department of Forestry and Fire Protection's  
Volunteers in Prevention - VIP Program.

\_\_\_\_\_  
(Parent or Guardian Signature)

\_\_\_\_\_  
(Date)

If you have any questions, please feel free to contact the  
VIP Coordinator for more information.

AT: \_\_\_\_\_

**CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION  
VOLUNTEER IN FIRE PREVENTION  
PARENT/GUARDIAN FIELD TRIP PERMISSION, WAVIER  
AND MEDICAL AUTHORIZATION (MINOR)  
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\_\_\_\_\_ Has my permission to work the following:

Fire Prevention Program: \_\_\_\_\_

Destination: \_\_\_\_\_

Dates: \_\_\_\_\_

Departure Time \_\_\_\_\_

Return Time \_\_\_\_\_

Type of Program \_\_\_\_\_

Person in charge \_\_\_\_\_

Pickup Location \_\_\_\_\_

Drop Off Location \_\_\_\_\_

Health Needs:  NO  YES

If Yes, please explain.

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgement of the attending physician, surgeon, or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I fully understand that participants are to abide by all rules and regulations governing conduct during the program.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of V.I.P.

\_\_\_\_\_  
Date

Family Medical Insurance Carrier \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_