APPLICATION FOR ASSISTANCE OR NOMINATION OF RECIPIENT FORM

Full legal name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact numbers: _____

Email: _____

Department currently employed by:_____

Years on the department: _____ Job Title:_____

Married? ☐ Yes ☐ No

Partner/ Spouse/ Significant Other's name: _____

Partner/ Spouse/ Significant Other's contact numbers: _____

Partner/ Spouse/ Significant Other's email: _____

# of Children: _____

Names and Ages:

Any other children/dependent family members living with you? Explain:

Please provide a brief description of the illness/injury:

How much time has this illness/injury required you to miss work?

Are you receiving short-or long-term disability for this injury/illness? ☐ Yes ☐ No

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Do we have your consent to contact your department about the illness/injury? ☐ Yes ☐ No

• Please list a contact person at your department:

Have you received financial assistance from another agency or foundation? ☐ Yes ☐ No

• If yes, please explain:

Is this illness/injury covered under Workman's Compensation? ☐ Yes ☐ No

How has this illness/injury affected your financial situation?

Please explain, how we can help you:

Provide name/address/phone number/email of 3 references: (A family member may not be listed)

1. Name: _____

Address: _____

Email:_____Phone:_____

2. Name: _____

Address: _____

Email:_____ Phone:_____

3. Name: _____

Address: _____

Email:_____Phone:_____

Please return application to: info@rockwallfirefighters.org