

**COUNTY OF MONMOUTH
OFFICE OF THE FIRE MARSHAL**

1027 HIGHWAY 33 EAST
FREEHOLD, NEW JERSEY 07728-9998

HENRY A. STRYKER III
FIRE MARSHAL

OFFICE: 732-683-8856
FAX: 732-683-8864

Web-ID Card Instructions

Please submit the following items along with your completed Web-ID Application:

1. Complete all items of the application where highlighted. If you wish to provide any other information on the form, please feel free to do so.
2. Provide copies of (2) Two photo ID's **OR** a copy of your passport.
3. Provide your DFS Firefighter 1 number..

Your photo will be taken by the Fire Marshal's Office.

Identification Card Application Form

Application Type (Check 1): Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Replacement – Damaged <input type="checkbox"/> Replacement – Lost <input type="checkbox"/> Replacement – Stolen <input type="checkbox"/>			
Employee Information			
Employee Affiliation: Government <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer <input type="checkbox"/>			
Employee ID Number:	Driver's License Number/MVC ID Number:	Driver's License State / MVC ID State:	
Last Name:	First Name:	Middle Initial:	
Date of Birth: (MM/DD/YYYY)	Height: (FT' Inches")	Eye Color:	Hair Color:
Citizenship: U.S. Citizen <input type="checkbox"/> Foreign National <input type="checkbox"/>			
Municipality / County / State (Circle Appropriate Jurisdiction)	Name of Municipality / County: (If Municipality /County Circled)		
Name of Department / Company:		Name of Agency:	
Work Telephone #:	Title:	Badge or ID #: (If applicable)	
Business Address:	City:	State:	Zip Code:
E-Mail Address:			
First Responder: Yes <input type="checkbox"/> No <input type="checkbox"/>	State Employee Designation: Business Continuity <input type="checkbox"/> Red Essential <input type="checkbox"/> (Check all that apply) Weather Essential <input type="checkbox"/>		
Employee Vetting Level: Level -1 <input checked="" type="checkbox"/> Level - 2 <input type="checkbox"/> Level - 3 <input type="checkbox"/> Level - 4 <input type="checkbox"/> (Check 1)			
Department Information			
Supervisor Name:		Supervisor Title:	
Department / Agency Name:			
Business Address:	City:	State:	Zip Code:
Work Telephone #:	E-Mail Address:		
Signature:	Date (MM/DD/YYYY):		
ID Card Coordinator Information			
Name:		Title:	
Department / Agency Name:			
Business Address:	City:	State:	Zip Code:
Work Telephone #:	E-Mail Address:		
Signature:	Date (MM/DD/YYYY):		
Registrar Information			
Name:		Title:	
Department / Agency Name:			
Business Address:	City:	State:	Zip Code:
Work Telephone #:	E-Mail Address:		
Signature:	Date (MM/DD/YYYY):		

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Last Name, First Name, Middle Initial (Page 2) <i>(Please print)</i>			
ID Credential Source Documents			
Source Document # 1:			
Issuing Authority:	Number:	Expiration (MM/DD/YYYY):	
Additional Information:			
Source Document # 2:			
Issuing Authority:	Number:	Expiration (MM/DD/YYYY):	
Additional Information:			
Card Issuer Information			
Name:		Title:	
Department / Agency Name:			
Business Address:	City:	State:	Zip Code:
Work Telephone #:		E-Mail Address:	
Signature:		Date (MM/DD/YYYY):	

I hereby request one Identification Card. I understand the following:

1. The Identification Card is issued to me in my name and shall be used only by me. It shall not be given, loaned, transferred, or otherwise used by another individual.
2. If the identification Card is lost, I must report the loss of the card to my supervisor immediately. A \$5.00 fee will be charged for a replacement card.
3. Upon any material change in the information provided on this form, a new Identification Card must be obtained and the old Identification Card given to the Card Issuer.
4. Upon cessation of employment, the Identification Card must be returned to my Supervisor.

Applicant Signature

Date (MM/DD/YYYY)

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Last Name, First Name, Middle Initial (Page 3) (Please print)			
Identifying Data (First Responder Only)			
Home Address:	City:	State:	Zip Code:
Medical Information			
Emergency Contact Name:		Emergency Contact Telephone #:	
Physician Name:		Physician Telephone #:	
Health Insurance Carrier:		Health Insurance Policy #:	
Organ Donor: Yes <input type="checkbox"/> No <input type="checkbox"/> (Check 1)			
Blood type and Rh: A -- <input type="checkbox"/> A+ <input type="checkbox"/> AB -- <input type="checkbox"/> AB+ <input type="checkbox"/> B-- <input type="checkbox"/> B+ <input type="checkbox"/> O -- <input type="checkbox"/> O+ <input type="checkbox"/> (Check 1)			
Blood Pressure (#/#):		Resting Pulse Rate:	
Any known allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please list)			
Any current medications? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please list)			
Significant Medical History: Yes <input type="checkbox"/> No <input type="checkbox"/> (Please list)			
Religion:			

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