

Metro West Ambulance

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

Date: _____

Name _____ Social Security # _____
(Last) (First) (M.I.)

Address _____
(Street) (City) (State) (Zip)

Phone _____ Are you 21 years or older? () Yes () No Date of Birth _____

E-Mail _____

Are you a U.S. citizen or alien authorized to work in the U.S.? () Yes () No

EMPLOYMENT DESIRED

Position _____ Referred by? _____

Have you ever applied to this company before? () Yes () No When? _____

Are you presently employed? () Yes () No Date you would be available? _____

May we contact your present employer? () Yes () No () Later (Give date) _____

EDUCATION

<i>Name</i>	<i>Location</i>	<i>Major</i>	<i>Year</i>	<i>Graduate?</i>	<i>Degree</i>
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High School _____

College _____

Tech School _____

EMT /Paramedic Training _____

PROFESSIONAL DATA

State EMT # _____ Level _____ Exp. Date _____

National EMT # _____ Level _____ Exp. Date _____

Has your EMT certification or standing orders ever been suspended or revoked? _____

If yes, please provide details on separate sheet, place in an envelope and mark "Confidential".

Driver's License # _____ State _____ Exp. Date _____

Driving Citations or Moving Violations: _____

Felony convictions in last 7 years (Offense/Date)? _____

Military Service _____ Rank _____

Are you a current member of the National Guard or Reserves? () Yes () No

*The age discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 but less than 70 years of age. Metro West Ambulance is an equal opportunity employer.

WORK HISTORY

Employer/Address/Phone Position/Description Supervisor

From: _____

To: _____

Reason For Leaving:

From: _____

To: _____

Reason For Leaving:

From: _____

To: _____

Reason For Leaving:

REFERENCES (People you have known for at least 1 year who are not related to you.)

Name Address Phone Occupation Years Known

PHYSICAL RECORD

Do you have any physical limitations that restrict you from performing any work for which you are being considered (such as lifting objects, hearing, vision, etc.?) Yes No

If yes, please describe: _____

Do you use tobacco products? Yes No

In case of emergency notify: _____
(Name) (Address) (Phone)

QUALIFICATIONS

What contributions do you feel you can make to this company?

- I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and pertinent information that may have, personal or otherwise, and release all parties from all liability for any damage that my result from furnishing same to you.

Signature _____ Date _____