



DATE: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

**EMPLOYMENT APPLICATION**

POSITION DESIRED: 1st CHOICE \_\_\_\_\_  
 2nd CHOICE \_\_\_\_\_

NAME: LAST	FIRST	MIDDLE
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ADDRESS: NUMBER	STREET	CITY	STATE	ZIP
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HOME TELEPHONE: ( ) ( )	BUSINESS TELEPHONE: ( ) ( )	E-MAIL ADDRESS:	DATE AVAILABLE:
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HOURS AVAILABLE TO WORK: \_\_\_\_\_

**EDUCATIONAL BACKGROUND**

TYPE OF SCHOOL	NAME AND LOCATION	DEGREE OBTAINED	GRADUATE
HIGH SCHOOL			YES NO
COLLEGE			YES NO
PROFESSIONAL SCHOOL			YES NO
TECHNICAL SCHOOL			YES NO

**UNITED STATES ARMED FORCES RECORD:**

BRANCH	SKILLS ACQUIRED
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**PROFESSIONAL LICENSE (PLEASE CHECK APPROPRIATE LINES, STATE(S) LICENSED IN, AND EXPIRATION DATES)**

LEVEL	STATE	EXPIRATION DATE
PARAMEDIC _____	_____	_____
EMT-BASIC _____	_____	_____
1st. RESPONDER _____	_____	_____
EMD _____	_____	_____
DRIVER'S LIC. _____ (CLASS)	_____	_____
ACLS _____	_____	_____
CPR _____	_____	_____

**WORK HISTORY**

ARE YOU PRESENTLY EMPLOYED? YES NO IF YES, MAY WE CONTACT YOUR PRESENT EMPLOYER? YES NO

**LIST PRESENT OR MOST RECENT EMPLOYER FIRST:**

EMPLOYER	ADDRESS/TELEPHONE	JOB TITLE

  

DATE STARTED	DATE ENDED	STARTING RATE	FINAL RATE	REASON FOR LEAVING
		\$ /HR.	\$ /HR.	

  

IMMEDIATE SUPERVISOR	DESCRIBE WORK PERFORMED
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<b>EMPLOYER</b>		<b>ADDRESS/TELEPHONE</b>		<b>JOB TITLE</b>
<b>DATE STARTED</b>	<b>DATE ENDED</b>	<b>STARTING RATE</b> \$ /HR	<b>FINAL RATE</b> \$ /HR	<b>REASON FOR LEAVING</b>
<b>IMMEDIATE SUPERVISOR</b>		<b>DESCRIBE WORK PERFORMED</b>		

<b>EMPLOYER</b>		<b>ADDRESS/TELEPHONE</b>		<b>JOB TITLE</b>
<b>DATE STARTED</b>	<b>DATE ENDED</b>	<b>STARTING RATE</b> \$ /HR	<b>FINAL RATE</b> \$ /HR	<b>REASON FOR LEAVING</b>
<b>IMMEDIATE SUPERVISOR</b>		<b>DESCRIBE WORK PERFORMED</b>		

<b>EMPLOYER</b>		<b>ADDRESS/TELEPHONE</b>		<b>JOB TITLE</b>
<b>DATE STARTED</b>	<b>DATE ENDED</b>	<b>STARTING RATE</b> \$ /HR	<b>FINAL RATE</b> \$ /HR	<b>REASON FOR LEAVING</b>
<b>IMMEDIATE SUPERVISOR</b>		<b>DESCRIBE WORK PERFORMED</b>		

**REFERENCES**

NAME THREE PERSONS (NOT RELATED) WHO HAVE KNOWLEDGE OF YOUR PROFESSIONAL QUALIFICATIONS AND WHOM WE HAVE PERMISSION TO CONTACT IMMEDIATELY, PREFERABLY PERSONS UNDER WHOM YOU HAVE WORKED. PREVIOUS EMPLOYERS/ SUPERVISORS MAY BE CONTACTED IMMEDIATELY FOR REFERENCES.

<b>NAME</b>	<b>TITLE OR OCCUPATION</b>	<b>EMPLOYER</b>	<b>BUSINESS PHONE</b>

**PERSONAL**

ARE YOU UNDER 18 YEARS OF AGE? YES NO

ARE YOU A U. S. CITIZEN OR RESIDENT ALIEN? YES NO PENDING, EXPLAIN: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A MISDEMEANOR? YES NO IF YES, EXPLAIN: \_\_\_\_\_

NOTE: CONVICTION OF A CRIME IS NOT NECESSARILY GROUNDS FOR DISQUALIFICATION.

BY WHAT SOURCE WERE YOU REFERRED TO MEDIC EMS FOR EMPLOYMENT? \_\_\_\_\_

HAVE YOU EVER BEEN EMPLOYED BY MEDIC EMS? YES NO IF YES, DATES EMPLOYED \_\_\_\_\_

DO YOU HAVE ANY RELATIVES EMPLOYED AT MEDIC EMS?

NO YES IF YES, NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**GENERAL INFORMATION**

PLEASE INCLUDE ANY OTHER INFORMATION YOU THINK WOULD BE HELPFUL TO US IN CONSIDERING YOU FOR EMPLOYMENT, SUCH AS ADDITIONAL WORK EXPERIENCE, ACTIVITIES, ACCOMPLISHMENTS, ETC. (YOU MAY EXCLUDE ALL INFORMATION INDICATIVE OF AGE, RACE, RELIGION, COLOR, NATIONAL ORIGIN, OR DISABILITY.)

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**SPECIAL NOTE: YOU ARE REQUIRED TO SUBMIT A MOTOR VEHICLE REPORT FROM YOUR LICENSING STATE ALONG WITH YOUR APPLICATION. THE REPORT MUST BE DATED NO MORE THAN 10 DAYS BEFORE YOUR APPLICATION SUBMISSION.**

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS (STREET) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE (\_\_\_\_) \_\_\_\_\_

MEDIC EMS IS AN EQUAL OPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE IN HIRING OR EMPLOYING, IN ACCORDANCE WITH THE REQUIREMENTS OF ALL APPLICABLE STATE AND FEDERAL LAWS, ON THE BASIS OF RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, ANCESTRY, MARITAL STATUS, UNFAVORABLE MILITARY DISCHARGE, HANDICAP OR AGE. NO QUESTION ON THIS APPLICATION IS INTENDED TO SECURE INFORMATION TO BE USED FOR SUCH DISCRIMINATION. IT IS THE POLICY OF MEDIC EMS TO PERFORM PRE-EMPLOYMENT DRUG TESTING. IN COMPLETING THIS APPLICATION, I CERTIFY THAT I UNDERSTAND THE QUESTIONS AND STATEMENTS CONTAINED IN THIS FORM IN THEIR ENTIRETY AND THAT MY EMPLOYMENT IS SUBJECT TO REFERENCES BEING OBTAINED AND TO SUCCESSFUL COMPLETION OF A PRE-EMPLOYMENT DRUG SCREEN AND PHYSICAL ASSESSMENT. I ALSO UNDERSTAND THAT ANY MISREPRESENTATION OR OMISSION OF THE FACTS REQUESTED IN THIS APPLICATION OR ANY OTHER MEDIC EMS DOCUMENT THAT I COMPLETE MAY BE CAUSE FOR THE REJECTION OF MY APPLICATION OR MY IMMEDIATE TERMINATION SHOULD I BE EMPLOYED BY MEDIC EMS. IN ADDITION, I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REGARDING MY SCHOOL RECORDS OR PREVIOUS EMPLOYMENT AND HEREBY RELEASE ALL PARTIES FROM ANY AND ALL LIABILITY OF DAMAGES FROM PROVIDING THE INFORMATION REQUESTED. IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF MEDIC EMS AND AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE AT ANY TIME, AT THE OPTON OF EITHER MEDIC EMS OR MYSELF. I UNDERSTAND THAT MY APPLICATION WILL BE KEPT ON FILE FOR A PERIOD OF SIX MONTHS. AT THE END OF THAT PERIOD MY APPLICATION WILL BECOME INACTIVE. IF I WANT TO BE GIVEN FURTHER EMPLOYMENT CONSIDERATION, I WILL BE REQUIRED TO UPDATE MY APPLICATION WITH THE PERSONNEL DEPARTMENT.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**FOR OFFICE USE ONLY**

HIRED AS : EMT-P EMT-B SCC WC/SHUTTLE OTHER \_\_\_\_\_

STARTING DATE \_\_\_\_\_ STARTING RATE \$ \_\_\_\_\_ /HR STATUS: FT SUPPLEMENTAL EMPLOYEE NUMBER \_\_\_\_\_

EMPLOYEE BIRTHDATE \_\_\_\_\_ DATE HIRED \_\_\_\_\_

EXECUTIVE DIRECTOR SIGNATURE: \_\_\_\_\_

*MEDIC EMS  
1204 E. HIGH ST.  
DAVENPORT, IA. 52803*

PLACE  
STAMP  
HERE

*MEDIC EMS  
1204 E. HIGH ST.  
DAVENPORT, IA 52803*

FOLD IN HALF AND STAPLE MIDDLE FOR MAILING