**ELLSWORTH AREA AMBULANCE SERVICE**

**151 South Plum Street**

**Ellsworth, WI 54011**

**715-273-4879**

**Application for Employment**

**Ellsworth Area Ambulance Service is an Affirmative Action-Equal Opportunity Employer**

**All employees are classified as “at will”**

**Personal Information**

**Last Name: First: M.I:**

**Permanent Address:**

**Current Address:**

**Telephone Number: (\_\_\_)**

**Work Phone Number: (\_\_\_)**

**Emergency Contact: Phone: (\_\_\_)**

**Date of Birth: Social Security Number:**

**Driver’s License Number:**

**EDUCATION**

**Highest Grade completed in School: Location:**

**National Registry Number: WI EMT License:**

**Basic Course Completed (Date and Location):**

**IV Tech Course: (Date and Location):**

**Paramedic Course: (Date and Location):**

**Recent Refresher Course (Date and Location):**

**CPR Certification: Yes No Expiration Date:**

**SERVICE AFFILIATION**

**Have you been or are you affiliated with any other ambulance service? Yes No**

**If yes, service name and location:**

**Supervisor: Phone Number:**

***Please note: A criminal & caregiver background check will be conducted prior to employment***

**MISCELLANEOUS:**

**In order to process this application you *must* enclose the following items:**

* **A completed criminal background information disclosure form**
* **A copy of your current driver’s license**
* **A copy of your current CPR card (front & back if able)**
* **A copy of your national registry card (front & back if possible)**

**MEDICAL HISTORY**

**Please indicate any medications you currently take, or any medical problems that you may have, that may affect your work experience as an EMT, including allergies:**

**AVAILABILITY**

**Please check when you are available to take on-call time:**

**Daytime Night time Weekend**

**REFERENCES**

**Please list 3 references unrelated to you who have known you for at least one year:**

**Name:**

**E-Mail: Phone Number: (\_\_\_)**

**Name:**

**E-Mail: Phone Number (\_\_\_)**

**Name:**

**E-Mail: Phone Number (\_\_\_)**

**AUTHORIZATION**

**“I certify that the facts contained in the application are true and complete to the best of my knowledge and I understand that any falsification, misrepresentation or omission shall be grounds for dismissal from the service.”**

**Signed:**

**Date:**

**RELATED WORK EXPERIENCE**

**Have you any other experience working in the field of health care? Yes No**

**If yes, in what capacity and how long?**

**Supervisor: Phone Number: (\_\_\_)**

**Please list any information or skills you think might be of help in considering your application.**

**PAST EMPLOYERS**

**Please give names of your current or past three employers.**

**Employer:**

**City, State: Phone Number (\_\_\_)**

**Position Held: From: To:**

**Supervisor: E-Mail:**

**Employer:**

**City, State: Phone Number (\_\_\_)**

**Position Held: From: To:**

**Supervisor: E-Mail:**

**Employer:**

**City, State: Phone Number (\_\_\_)**

**Position Held: From: To:**

**Supervisor: E-Mail:**

**CRIMINAL INFORMATION**

**Have you ever been convicted of a crime? \*Yes No**

**Do you have any pending criminal charges awaiting disposition at this time? \*Yes No**

**\*If you answered yes to either question, please provide information of arrest, nature of each charge or conviction, related circumstances and final disposition on a separate page. Include dates and any other necessary information.**