

FOR OFFICE USE ONLY		
Application Review	Date:	Clock:
Date of Hire:	Time Card #:	Rate:

PHYSICIANS
Medical Transport Team
“A DRUG FREE WORK PLACE”
EMPLOYMENT APPLICATION

Physicians Medical Transport Team is an Equal Opportunity Employer. It is our policy to abide by all Federal, State, and local laws concerning discrimination in employment. No question in this application is intended to elicit information in violation of any such law nor will any information obtained in response to any question be used in violation of any such law.

LAST	FIRST	MIDDLE	Date:
STREET			Social Security #:
CITY	STATE	ZIP	Home Phone #:
POSITION APPLYING FOR			Pager #:
Were you previously employed by this organization? If YES, please list the dates of employment. Yes () No ()			Cell Phone #:
List any relatives or friends employed by Physicians Medical Transport Team.			E-mail Address:
			Wages Expected:

NAME	RELATIONSHIP
List any relatives or friends employed by Physicians Medical Transport Team.	

NAME	PHONE #
In case of accident, notify:	

EDUCATION	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	NUMBER OF YEARS	DID YOU GRADUATE?

List any Diplomas or Degrees you have received:

EMS TRAINING

EMS CERTIFICATION INFORMATION

ALL EMS APPLICATIONS MUST INCLUDE A CURRENT COPY OF YOUR OHIO EMT CARD, CPR CARD AND DRIVERS LICENSE. PARAMEDICS MUST ALSO INCLUDE YOUR ACLS CARD.

TYPE OF OHIO CERTIFICATION

CERTIFICATION NUMBER

EXP. DATE

DATE OF BIRTH

DRIVERS LICENSE #

STATE

All EMS applications will be submitted for a driver background check.

WHEELCHAIR DRIVER INFORMATION

DATE OF BIRTH

DRIVERS LICENSE #

STATE

All wheelchair applicants as per Ohio Revised Code will submit to driver background check, drug test, physical exam and finger print background check.

Please list all criminal violations in the past or pending:

Date	Offence	Filing Court	Outcome
/ /		/	/
/ /		/	/

Positions at Physicians Ambulance require lifting, bending, Are you able to perform the job(s) for which you are applying?

WORK EXPERIENCE

List Present and Former Employers dating back to the last 10 years beginning with the most recent

NAME AND ADDRESS OF COMPANY	SUPERVISOR	DESCRIBE YOUR WORK	LAST WAGE	DATES OF JOB	DEPARTURE REASON
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May we contact the above employers? YES NO *Place a check in the appropriate box.*

Additional Remarks:

APPLICANT'S CERTIFICATION
Please read carefully before signing.

I certify that, to the best of my knowledge and belief, the answers given by me to the foregoing questions and the statements made by me in this application are correct and complete. I understand that misrepresentation or omission of facts in this application may lead to my discharge.

I understand that Federal, State and Local requirements govern the position I am applying for and I will comply with all laws including fingerprint background check, physical exams and drug screening both routine and random. I also understand that additional training may be required in order to continue my employment with Physicians Ambulance Service.

If employed, I understand and agree that such employment may be terminated at any time, without prior notice, and that employment will not be governed by any expressed or implied contract, but is at will.

APPLICANT'S SIGNATURE

DATE

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DO NOT WRITE BELOW – FOR COMPANY USE ONLY

INTERVIEW:

DATE OF INTERVIEW:

HOUR:

RESULTS OF INTERVIEW:

PRE-EMPLOYMENT PHYSICAL PASS FAIL DRUG SCREEN PASS FAIL

BACKGROUND CHECK: DRIVING YES NO CRIMINAL PASS FAIL

ACCEPTABLE FOR EMPLOYMENT? YES NO

STARTING RATE: _____ STARTING DATE: _____ SHIFT _____

INTERVIEWER:

DATE:

APPROVED BY:

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Physicians Medical Transport Team

DISCLOSURE UNDER
FAIR CREDIT REPORTING ACT
AND
CONSENT TO PROCUREMENT OF
CONSUMER REPORT FOR EMPLOYMENT PURPOSES

The undersigned hereby authorizes Physicians Ambulance Service or its insurance agency Neale Phypers Corporation, or its assigns, to obtain copies of consumer reports, including a motor vehicle report, pertaining to me for employment purposes, and for use in rating and/or underwriting insurance for which the above-named employer may apply, and any renewal thereof. I understand that in obtaining such consumer reports, a consumer reporting agency may be used.

I hereby authorize release to Physicians Ambulance Service information held by parties regarding my previous employment, conviction history, driving history, education or degrees earned, Credit history in compliance with all federal and state laws, and hereby release any providers of such information from any liability for providing same. I understand this information may be reviewed initially and periodically by these parties prior to and/ during employment.

I understand this information is to be utilized as a part of the employment process. I also authorize investigation into my worker's compensation claim history if a conditional offer of employment is made to me, in compliance with A.D.A guidelines; so as to assure I am not being offered a position, which could aggravate a previous injury.

I hereby acknowledge that Physicians Ambulance used third party information and cannot guarantee the accuracy of any such information. I therefore release Physicians Ambulance Service, its agents, my employer or prospective employer and its agents from any and all liability arising out of any errors or omissions regarding this investigation into my background, and authorize the background investigate agency to proceed with this investigation and release the results.

Date: _____ Print Name _____

Signed

Date of birth _____

Social Security # _____

Driver's License # _____ / State _____

Internal use only, Fax: 216-524-7450

Return to:

Ed Joe Kathy