



Application for Employment

Our policy is to provide equal employment opportunity to all qualified persons without regard to race, creed, color, religious belief, sex, age, national origin, ancestry, physical or mental disability, or veteran status.

Date _____

*Email: _____

Last Name: _____	First Name: _____	M.I. _____
Street Address _____		City: _____
State _____	ZIP _____	Telephone _____ Social Security # _____
Are you a U.S. citizen or otherwise authorized to work in the U.S. on an unrestricted basis? (You may be required to provide documentation.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Desire full-time or Part-time employment? <input type="checkbox"/> Full Time or <input type="checkbox"/> Part Time Preferred shift? _____		
Hours available to work? _____		Are you willing to work some evenings? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing to work weekends or an occasional Holiday for higher wages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been convicted of a crime? Felony or misdemeanor (circle as applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date(s) and describe events. _____ _____ _____		
EMT Certified: Basic <input type="checkbox"/> , Interm <input type="checkbox"/> , Medic <input type="checkbox"/> / CPR Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No / 1st Aid Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Defensive Driving Course Completion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: _____ Licensed to drive by Ohio (BMV) with a clean driving record in last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Employment information:

Position being applied for: _____

How did you hear of this opening? _____

Have you ever applied for, or worked for Ohio Medical Transport, LLC? Yes No When? _____

Are you presently employed? Yes No May we contact your present employer? Yes No

Employer contact name/number: _____

Are you aware of anything that might hinder your ability to effectively perform work with Ohio Medical Transport, LLC ? Yes No If yes, please describe: _____

Date you can begin employment: _____ Desired position: _____

Expected starting hourly wage/salary: _____ Please list applicable skills: _____

Education

School Name and Location	Year	Major	Degree
High School _____	_____	_____	_____
College _____	_____	_____	_____
College _____	_____	_____	_____
Other Training _____	_____	_____	_____

In addition to your work history, are there are other skills, qualifications, or experience that you believe would make you well-suited for work with Ohio Medical Transport, LLC?

Please list any scholastic honors, awards received, offices held in school or volunteer activities.

Are you planning to continue your educational studies? Yes No

Employment History (Start with most recent employer)

1. Company Name _____	
Address _____	Telephone _____
Date Started _____ Starting Wage _____	Starting Position _____
Date Ended _____ Ending Wage _____	Ending Position _____
Name of Supervisor _____	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone: _____	Responsibilities: _____
Reason for leaving _____	
2. Company Name _____	
Address _____	Telephone _____
Date Started _____ Starting Wage _____	Starting Position _____
Date Ended _____ Ending Wage _____	Ending Position _____
Name of Supervisor _____	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone: _____	Responsibilities: _____
Reason for leaving _____	
3. Company Name _____	
Address _____	Telephone _____

3. *Employment Information continued*

Date Started _____ Starting Wage _____ Starting Position _____

Date Ended _____ Ending Wage _____ Ending Position _____

Name of Supervisor _____ May we contact? Yes No

Phone: _____ Responsibilities: _____

Reason for leaving _____

4. *Company Name*

Address _____ Telephone _____

Date Started _____ Starting Wage _____ Starting Position _____

Date Ended _____ Ending Wage _____ Ending Position _____

Name of Supervisor _____ May we contact? Yes No

Phone: _____ Responsibilities: _____

Reason for leaving _____

5. *Company Name*

Address _____ Telephone _____

Date Started _____ Starting Wage _____ Starting Position _____

Date Ended _____ Ending Wage _____ Ending Position _____

Name of Supervisor _____ May we contact? Yes No

Phone: _____ Responsibilities: _____

Reason for leaving _____

References

Please list 3 personal references, not related to you, who have known you for more than one year.

Name _____ Phone _____ Years Known _____

Address, City, State, Zip: _____

Name _____ Phone _____ Years Known _____

Address, City, State, Zip: _____

Name _____ Phone _____ Years Known _____

Address, City, State, Zip: _____

Emergency Contacts:

In case of emergency, please notify:

Name _____ Phone _____

Name _____ Phone _____

Please Read Before Signing:

I certify that all information provided by me on this application is true and complete to the best of my knowledge and that I have withheld nothing that, if disclosed, would alter the integrity of this application.

I authorize my previous employers, schools, or persons listed as references to give any information regarding employment or educational record. I agree that this company and my previous employers will not be held liable in any respect if a job offer is not extended, or is withdrawn, or employment is terminated because of false statements, omissions, or answers made by myself on this application. In the event of any employment with this company, I will comply with all rules and regulations as set by the company in any communication distributed to the employees.

In compliance with the Immigration Reform and Control Act of 1986, I understand that I am required to provide approved documentation to the company that verifies my right to work in the United States on the first day of employment. I have received from the company a list of the approved documents that are required.

I understand that employment at this company is “at will,” which means that either I or Ohio Medical Transport, LLC can terminate the employment relationship at any time, with or without prior notice, and for any reason not prohibited by statute. All employment is continued on that basis. I hereby acknowledge that I have read and understand the above statements.

Printed Name: _____

Signature _____ Date _____

www.OhioMedicalTransport.com

Mailing Address: P.O. Box 353 Tipp City, OH 45371

Phone: 937-877-1235 Fax: (937) 877-1276