

# FREEPORT EMERGENCY MEDICAL SERVICES

PO Box 158 400 Market Street Freeport, PA 16229

Phone: 724-295-2300 Fax: 724-295-2970

## APPLICATION FOR EMPLOYMENT

Full Name:		DOB:	
Address:			
City:		State:	
		Zip:	
Phone #:		DL Number:	
Email:		SSN:	

Have you ever been convicted of a crime?  Yes  No If yes, please explain below:

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**EMS Certification Level:**     EMT     AEMT     Medic     PHRN     Other  
**Employment Type:**             Full-Time     Part-Time/Casual     Volunteer/Call-Back

**Emergency Services Training (Copies to be provided):**

	Certification #	Date Received	Expiration Date
PA: EMT / AEMT / Medic / PHRN			
National Registry: EMT / AEMT / Medic			
BLS/CPR			
EVOC/EVDT/EVOT			
ACLS			
PALS			
ITLS / PHTLS / BTLs			

Other Emergency Services Training: \_\_\_\_\_

Do you currently have Medical Command?  Yes     No    Facility: \_\_\_\_\_

**Current and Previous Employment**

Dates:	Organization:	Contact/Phone #:

**References (one must be Professional in nature)**

Name:		Relation:	
Phone:		Email:	

Name:		Relation:	
Phone:		Email:	

Name:		Relation:	
Phone:		Email:	

**APPLICANT SIGNATURE:**

By signing this application, I confirm that all of the information contained herein is true and correct to the best of my knowledge and that no intentional omission of requested information has occurred. Furthermore, I indicate by my signature below that I grant permission for representatives of the Freeport EMS to contact individuals, employers, educational and any other entities which become known through this verification process for the purpose of background verification. I understand that both criminal history and child welfare clearance checks shall be obtained as a condition of employment. It is my clear understanding that this application may or may not result in employment with Freeport EMS and that the presence of criminal history and/or child welfare violations, and/or any false information included in the application, may preclude further processing of this application for membership and this application for membership may be denied. Applications shall be retained for six (6) months, after which re-application shall be required.

Signature of Applicant: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Submission: \_\_\_\_\_

*Freeport EMS is an Equal Opportunity Employer as required by local, state, and federal laws.*