

PHYSICIANS

MEDICAL TRANSPORT
TEAM

A DRUG FREE WORKPLACE

All applicants must submit to a drug test and agree to the company Drug Free Policy

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.

Date _____ Position Applying For _____

Name _____ DOB / /
Last First Middle

Address _____ SS # - -
Street

Email Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Were you previously employed by this organization? NO YES Dates of employment _____

Do you know anyone employed by Physicians? NO YES

If yes, list name and relationship _____

In case of emergency notify _____
Name Relationship Phone Number

Education Information

Name of School	Location	Course of Study	Years Attended	Diploma/Degree Received	Did You Graduate?

Please list all criminal violations in the past or pending

Date	Offense	Filing Court	Outcome

EMS and Wheelchair Driver Applicants must be able to lift, bend, and twist.

Are you able to fulfill this requirement? _____ Initial _____

EMS Applicants

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

EMS APPLICANTS WILL BE SUBMITTED FOR A DRIVER, WORK, AND CRIMINAL BACKGROUND CHECK.

Type of OHIO Certification	Certification Number	Expiration Date

Drivers License Number	State	Expiration Date

List any additional certifications or training: _____

Wheelchair Driver Applicants

ALL WHEELCHAIR APPLICANTS MUST INCLUDE A COPY OF THEIR CURRENT DRIVERS LICENSE.

WHEELCHAIR DRIVER APPLICANTS WILL BE SUBMITTED FOR A DRIVER, WORK, AND CRIMINAL BACKGROUND CHECK.

AS PER THE OHIO REVISED CODE, WHEELCHAIR APPLICANTS MUST SUBMIT TO A DRUG TEST, PHYSICAL EXAM, AND FINGER PRINT BACKGROUND CHECK.

Drivers License Number	State	Expiration Date

List any additional certifications or training: _____

Additional Comments: _____

Work Experience

List present and former employers dating back to the last 10 years beginning with the most recent

Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason
Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason
Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason
Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason
Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason
Employer	Address	Supervisor	Dates of Job
Describe Your Work		Phone Number	Departure Reason

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 an expressed or implied contract, but is at will.

Signature _____

Date _____

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 Phipers 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.

Print Name

Signature

Date

Date of Birth

Social Security Number

Drivers License Number

State

Notes

Notes section with multiple horizontal lines for text entry.

Date Background/Work Check	Results	In File
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Date of Driving Check	Results	In File
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Date of Drug/Physical	Results	In File
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Date and Time of Interview	Interviewer
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Interview Notes section with multiple horizontal lines for text entry.

Approved for Employment?

Approved By

Position	Full or Part Time	Starting Wage	Date of Hire
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HR initial receipt of the following

- Drivers License
- 2nd Form of ID _____
- State Card
- CPR
- ACLS(medics only)
- New Hire Packet
- Drug Test
- Physicial
- Drug/HIPAA Signoff sheet
- HIPAA Test
- Date Fingerprints Sent _____
- BCI Check Received
- FBI Check Received
- Information in EMS Manager
- Time Card Issued
- Employee Number _____