LEHIGHTON AMBULANCE ASSOCIATION, INC.

PRE-EMPLOYMENT QUESTIONNAIRE

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Lehighton Ambulance Association, Inc. recognizes that all persons are entitled to equal employment opportunities, and in its recruitment for employment or volunteers, training and compensation practices, the best qualified individual, based on organizational requirements, shall be selected, without regard to race, creed, color, sex, or national origin, as well as mental and physical handicaps that do not interfere with job performance.

NAME: ____DATE:_________________________
(Last) (First) (MI)

ADDRESS:____
(Street/P.O. Box) (City) (State) (ZipCode)

Pager/Cell Number (_____)____________________ Carrier:_______________

TELEPHONE NUMBER: (_______)_____________SOCIAL SECURITY #:_________________

Email address:____

POSITION DESIRED: ________FULL-TIME ________ PER-DIEM

HAVE YOU EVER PLEADED OR BEEN CONVICTED OF A CRIME OTHER THAN A MISDEMEANOR OR SUMMARY OFFENSE? YES_____ NO_____

IF YOU HAVE BEEN CONVICTED OF A FELONY, THE NATURE OF THE FELONY AND THE LENGTH OF TIME SINCE CONVICTION WILL BE IMPORTANT EMPLOYMENT CONSIDERATIONS. YOU WILL NOT BE AUTOMATICALLY DISQUALIFIED FOR EMPLOYMENT BY LAA,INC. BECAUSE OF A PRIOR CONVICTION AND YOU WILL BE GIVEN THE OPPORTUNITY TO EXPLAIN ANY CONVICTIONS.

HAVE YOU EVER BEEN FIRED FROM A JOB FOR ANY REASON? YES______ NO______

IF YES, EXPLAIN:____

IF YOUR APPLICATION IS CONSIDERED FAVORABLY, ON WHAT DATE WILL YOU BE AVAILABLE?__________

EDUCATION

HIGH SCHOOL: NUMBER OF YEARS COMPLETED: 1 2 3 4

SCHOOL:___________________________ CITY:________________________________ STATE:__________________

DO YOU HAVE A HIGH SCHOOL DIPLOMA? YES_____ NO_____ (OR) GED YES____ NO_____

COLLEGE: NUMBER OF YEARS COMPLETED: 1 2 3 4 5

SCHOOL:__________________________CITY:________________________________STATE:_________________

MAJOR:___________________________DEGREE:____

OTHER TRAINING:

SCHOOL:_________________________CITY:__________________________________STATE:________________

COURSE:_________________________DEGREE EARNED:____

EMERGENCY MEDICAL SERVICES TRAINING:

HIGHEST LEVEL OF TRAINING: FIRST RESPONDER____________________EMT_________________

OTHER________________________PARAMEDIC_________________HEALTH PROFESSIONAL_____________

DATE OF ORIGINAL CERTIFICATION:____

LOCATION OF ORIGINAL FIRST RESPONDER/EMT/PARAMEDIC/HPRN TRAINING:

SCHOOL:______________________CITY:______________________________STATE:____________________

HAS YOUR CERTIFICATION EVER LAPSED? YES____________ NO________________ N/A_____________

IF YES, E XPLAIN____

HAVE YOUR MEDICAL COMMAND PRIVILEGES EVER BEEN SUSPENDED? YES_______ NO______N/A____

IF YES, EXPLAIN____

IS THERE ANY LEGAL, MALPRACTICE OR DISCIPLINARY ACTION PENDING AGAINST YOU? YES____NO_____N/A_____

IF YES, EXPLAIN:____

CURRENT EMS REGION IN WHICH YOU SERVE: ____

CURRENT MEDICAL DIRECTOR'S NAME: __________________________TELEPHONE NUMBER:____________

ADDRESS:____
(STREET/P.O. BOX) (CITY) (STATE) (ZIP CODE)

CERTIFICATIONS WITH COPIES ATTACHED TO APPLICATION:

DRIVER'S LICENSE: DR. ID #_________________________ EXP.DATE __________
EVOC DATE TAKEN_________________________
(Circle One) **FR** **EMT** **PII** **HP**

CERT#__________________________ DATE_______________ 3 DIGIT______

CPR EXPIRATION DATE ___________________________________

ACLS EXPIRATION DATE _______________________________

PHTLS EXPIRATION DATE____________________________________

PALS EXPIRATION DATE____________________________________

HAZ MAT R & I EXPIRATION DATE OR DATE TAKEN__________________________
(CIRCLE ONE)

HEPTAVAX Y or N DATE TAKEN_________ EMPLOYEE PHYSICAL? ______________

TB TESTING Y or N DATE TAKEN_________

BLOOD BORNE PATHOGEN IN SERVICE DATE TAKEN_________

EMPLOYMENT HISTORY

COMPANY____

ADDRESS:____

PHONE:_______________START DATE:_______________LEAVE DATE:_________

SUPERVISOR'S NAME AND DEPARTMENT:_________________________________

JOB TITLE AND DUTIES:____

REASON FOR LEAVING:____

COMPANY: ____
ADDRESS:____
PHONE:_________________START DATE:____________LEAVE DATE:___________

SUPERVISOR'S NAME AND DEPARTMENT:__________________________________

JOB TITLE AND DUTIES:____

REASON FOR LEAVING: ____

COMPANY____

ADDRESS:____

PHONE:_______________START DATE:_______________LEAVE DATE:_________

SUPERVISOR'S NAME AND DEPARTMENT:_________________________________

JOB TITLE AND DUTIES:____

REASON FOR LEAVING:____

PROFESSIONAL REFERENCES

(1.) FULL NAME____

ADDRESS____

PHONE NUMBER_______________________________

OCCUPATION_____________________________

(2.) FULL NAME____

ADDRESS____

PHONE NUMBER_______________________________

OCCUPATION_____________________________

(3.) FULL NAME____

ADDRESS____

PHONE NUMBER_______________________________

OCCUPATION_____________________________

TO THE APPLICANT: READ CAREFULLY BEFORE SIGNING

I certify that all data provided on this application is true and accurate. I understand that it will be carefully checked and that misrepresentation or omission of facts on my part may be justification for separation from the Organization's services, if employed or accepted into membership.

I authorize you or my former employers or references to furnish any information concerning my personal background check or employment record . I hereby release from liability the employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information. I understand that if employment is obtained under this application, the organization does not guarantee employment for a fixed term.

This application is current for only 60 days. At the conclusion of this time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to fill out a new application

I understand that I am free to resign at any time, the employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the employer has the authority to make any assurances to the contrary.

I hereby agree to submit to a physical examination if requested by the organization and I attest to the fact that I am now physically capable of performing all responsibilities within the scope of the position for which I applied and understand that some heavy lifting will be required as part of an ambulance service.

____ ____

(Signature) (Date)

P.O Box 82
516 Iron Street
Lehighton, PA 18235

Phone #(610)377-5155 FAX # (610)377-5576

LEHIGHTON AMBULANCE ASSOCIATION
516 IRON STREET
P O BOX 82
LEHIGHTON, PA 18235
610-377-5155 FAX 610-377-5576

RELEASE FORM

I ____grant permission for the Lehighton Ambulance Association to obtain a Motor Vehicle Drivers history report and a Criminal History report, as often as required, or as deemed necessary, for as long as I am employed or volunteer for Lehighton Ambulance Association.

APPLICANT

NAME ____

Last First Middle Name

Maiden Name or Aliases

____

Address:____

Social Security:____

Date of Birth:_________ ___________ _______________

Operator License Number ______________________________

Signature:____