

# GLENWOOD CITY AMBULANCE SERVICE

10 Misty Lane, PO Box 368

Glenwood City, WI 54013

[glenwoodcityems@gmail.com](mailto:glenwoodcityems@gmail.com)

## Application for Employment

Glenwood City Ambulance Service is an Affirmative Action-Equal Opportunity Employer

### Personal Information

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Current Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

### EDUCATION

Highest Grade completed in School: \_\_\_\_\_ Location: \_\_\_\_\_

National Registry Number: \_\_\_\_\_ WI EMT License: \_\_\_\_\_

Basic Course Completed (Date and Location): \_\_\_\_\_

IV Tech Course: (Date and Location): \_\_\_\_\_

Paramedic Course: (Date and Location): \_\_\_\_\_

Recent Refresher Course (Date and Location): \_\_\_\_\_

CPR Certification: Yes  No  Expiration Date: \_\_\_\_\_

### SERVICE AFFILIATION

Have you been or are you affiliated with any other ambulance service? Yes  No

If yes, service name and location: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*Please note: A criminal & caregiver background check will be conducted prior to employment*

### MISCELLANEOUS:

In order to process this application you ***must*** enclose the following items:

- A completed criminal background information disclosure form
- A copy of your current driver's license
- A copy of your current CPR card (front & back if able)
- A copy of your national registry card (front & back if possible)

**MEDICAL HISTORY**

Please indicate any medications you currently take, or any medical problems that you may have, that may affect your work experience as an EMT, including allergies:

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**AVAILABILITY**

Please check when you are available to take on-call time:

Daytime  Night time  Weekend

**REFERENCES**

Please list 3 references unrelated to you who have known you for at least one year:

Name: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION**

“I certify that the facts contained in the application are true and complete to the best of my knowledge and I understand that any falsification, misrepresentation or omission shall be grounds for dismissal from the service.”

Signed: \_\_\_\_\_  
Date: \_\_\_\_\_

**RELATED WORK EXPERIENCE**

Have you any other experience working in the field of health care? Yes  No

If yes, in what capacity and how long? \_\_\_\_\_  
\_\_\_\_\_  
Supervisor: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Please list any information or skills you think might be of help in considering your application.

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**PAST EMPLOYERS**

Please give names of your current or past three employers.

Employer: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Position Held: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Supervisor: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Position Held: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Supervisor: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Position Held: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Supervisor: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**CRIMINAL INFORMATION**

Have you ever been convicted of a crime? \*Yes  No

Do you have any pending criminal charges awaiting disposition at this time? \*Yes  No

\*If you answered yes to either question, please provide information of arrest, nature of each charge or conviction, related circumstances and final disposition on a separate page. Include dates and any other necessary information.