

*Elite Medical Transport, LLC*  
*PO Box 929*  
*Santa Teresa, NM 88008*



**Main Telephone: (915) 542-1194**  
**Fax: 915-613-1693**

**EMPLOYMENT APPLICATION FORM**

*Elite Medical Transport (EMT) considers candidates for employment without regard to race, color, national origin, ancestry, religion, sex, age, disability, political belief, military service, or any other protected class.*

**EMT IS A DRUG-FREE WORKPLACE**

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_ Date Available: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 How did you find out about this position? \_\_\_\_\_  
 If any, please list relatives or friends employed here: \_\_\_\_\_

**POSITION INFORMATION**

Applying for job as: \_\_\_\_\_  Carlsbad  Deming  Portales  
 Available for scheduling:  Full Time  Part Time  Either  
 Have you been employed by Elite before?  YES  NO If so, when: \_\_\_\_\_  
 Prior position(s): \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
 Insert the hours and times of day you **ARE NOT** available to work for each day of the week:  
 Sun            Mon            Tues            Wed            Thu            Fri            Sat

**CERTIFICATION INFORMATION**  
*(Check all that apply - photocopies required at interview)*

	EMS/Nursing License/Certificate	National Certificate/License	Driver's License
<b>Cert/License#:</b>			
<b>Issued by:</b>			
<b>Exp. Date:</b>			
Check each of the certificates that you currently hold.			
<input type="checkbox"/> CPR	<input type="checkbox"/> ACLS	<input type="checkbox"/> PALS	<input type="checkbox"/> PHTLS
<input type="checkbox"/> NRP	<input type="checkbox"/> TNCC	<input type="checkbox"/> CCRN	<input type="checkbox"/> CCEMTP



**WORK REQUIREMENTS & AND GENERAL INFORMATION**

Can you provide proof, if hired, that you are eligible to work in the U.S.?  YES  NO

Can you provide a list of current immunizations if employed?  YES  NO

Have you ever been excluded or are you currently excluded from participating in any federal health program such as Medicare or Medicaid?  YES  NO

If yes, explain:

**EMPLOYMENT HISTORY**

*(List your last three employers or volunteer activities, starting with the most recent.)*

**EMPLOYER (1):**

Name & Address (1)

Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Start Date: \_\_\_\_\_ Salary: \_\_\_\_\_ End Date: \_\_\_\_\_ Salary: \_\_\_\_\_

Job Description (including duties and responsibilities): \_\_\_\_\_

Employer's Telephone #: \_\_\_\_\_ May we contact?  YES  NO

Reason for leaving: \_\_\_\_\_

**EMPLOYER (2):**

Name & Address (2)

Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Start Date: \_\_\_\_\_ Salary: \_\_\_\_\_ End Date: \_\_\_\_\_ Salary: \_\_\_\_\_

Job Description (including duties and responsibilities): \_\_\_\_\_

Employer's Telephone #: \_\_\_\_\_ May we contact?  YES  NO

Reason for leaving: \_\_\_\_\_

**EMPLOYER (3):**

Name & Address (3)

Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Start Date: \_\_\_\_\_ Salary: \_\_\_\_\_ End Date: \_\_\_\_\_ Salary: \_\_\_\_\_

Job Description (including duties and responsibilities): \_\_\_\_\_

Employer's Telephone #: \_\_\_\_\_ May we contact?  YES  NO

Reason for leaving: \_\_\_\_\_



**MILITARY SERVICE:**

Service Branch	Enlisted	Rank/Duties	Discharged

**COMPLIANCE HISTORY**

*Answers of Yes for any of the above questions will not necessarily disqualify you from employment.*

- Have you ever been:
- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Disciplined or terminated for reckless driving?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Placed on probation or terminated for excessive absenteeism?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Disciplined or fired for insubordination?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Disciplined or fired for violation of safety rules?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Disciplined or fired for assault or fighting?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Disciplined or fired for harassment?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Disciplined or fired for patient abuse?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Disciplined or fired for alcohol or drug related activity at work? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered yes to any question above, please explain:

**EDUCATION AND TRAINING**

**HIGH SCHOOL:**

Name: \_\_\_\_\_ City/State: \_\_\_\_\_  
Years completed: \_\_\_\_\_ Highest grade completed: \_\_\_\_\_  
Did you graduate?  YES  NO Have you received your GED?  YES  NO

**COLLEGE:**

Name: \_\_\_\_\_ City/State: \_\_\_\_\_  
Years completed: \_\_\_\_\_  
Did you graduate?  YES  NO Degree Achieved \_\_\_\_\_

**TECHNICAL SCHOOL:**

Name: \_\_\_\_\_ City/State: \_\_\_\_\_  
Years completed: \_\_\_\_\_  
Did you graduate?  YES  NO Certificate Achieved: \_\_\_\_\_

**OTHER SCHOOL/TRAINING:**

Describe any additional personal or professional qualifications, related employment information that you would like us to know about you or you feel would be beneficial for us to know when considering your application:



**REFERENCES**

List **three** persons, other than relatives, who have knowledge of your experience and/or education.

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone No. \_\_\_\_\_

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

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone No. \_\_\_\_\_

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

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone No. \_\_\_\_\_

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

**ACKNOWLEDGMENT**

I certify that the information I have given on this application is true, complete and correct, and I understand that any false information, or the omission of information may be considered as sufficient reason for my discharge if hired. I recognize that completion of this application does not mean that job openings exist and does not obligate the Company in any way. Applications will remain active for six months, after which time re-application will be necessary. If hired, employment will be "at will" and either I or the Company is free to terminate the employment relationship at any time without cause and without prior notice. This application is not an agreement or a contract for employment.

If offered a position and at any time thereafter, I consent to medical examinations as may be required to determine my fitness to perform the job duties.

I understand that I may be required to undergo drug screening tests as a condition of employment. To comply with this requirement, I consent to providing a sample of my urine or other physical samples (such as blood or hair) prior to employment and again at any time so requested. Specimens will be tested for both legal (prescription drugs) and illegal substances. A positive test for legal substances will require proof of a current prescription. I further consent to allow any doctor, hospital or testing laboratory to conduct any medical test or examination as may be required by the Company as a condition of my employment, and I hereby give my consent to the release of all information which the Company deems necessary to determine my ability to perform job duties now or in the future.

I further understand that refusal to submit to an alcohol or drug screen test at any time will result in immediate discharge from this Company.

I hereby authorize the Company to investigate my employment history with former employers and to make any further investigation deemed necessary in connection with my application for employment, including a criminal history check, driving history check, child abuse clearance check, and other such inquiries. I release the Company and all informants from all liability resulting from such inquiries. I waive all rights to see or review the information so furnished.

I certify that I am not now, nor have I ever been excluded from any state or federal health care program. I further understand that if it is determined that I was so excluded, my employment with the Company may be terminated.

Applicant's Signature: \_\_\_\_\_

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