



# APPLICATION

COMPLETE THIS ENTIRE APPLICATION AND RETURN TO:

Haddam Volunteer Ambulance Service, Inc.  
 Post Office Box 48  
 Higganum, CT 06441 Tel (860) 345-2500

## GENERAL INFORMATION

Date of Application:		Position Desired: <input type="checkbox"/> EMT <input type="checkbox"/> EMR <input type="checkbox"/> Non-Medical		
When Available to Work:		<input type="checkbox"/> Resident <input type="checkbox"/> Non-Resident		
Name		Last		First Middle
Current Address:		Number	Street	City State Zip
Cell Phone: ( )		Carrier:		Home Phone: ( )
Date of Birth: / /		Work Phone: ( )		
E-Mail:		Marital Status:		
In Case of Emergency Contact:		Phone: ( )		
Referral Source:				
Employed Here Before?				
<input type="checkbox"/> Yes		If YES, Gives Dates		
<input type="checkbox"/> No		Position & Reason for Leaving		
Are You a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				

## EDUCATION

Type of School	Name & Location	Years Attended From To	Course of Study	Did You Graduate?
High School (or G.E.D.)				
Technical (After High School)				
College				
Other				

## TRAINING & CERTIFICATION

NOTE: IT IS ILLEGAL TO RENDER EMERGENCY MEDICAL CARE WITH AN AMBULANCE SERVICE IN THE STATE OF CONNECTICUT WITHOUT CERTIFICATION FROM THE OFFICE OF EMERGENCY MEDICAL SERVICE IN HARTFORD. IT IS THE RESPONSIBILITY OF THE APPLICANT TO BE AWARE OF AND COMPLY WITH CONNECTICUT CERTIFICATION REQUIREMENTS: FAILURE TO MAINTAIN A REQUIRED CERTIFICATION CAN BE CAUSE FOR DISMISSAL.

Training Level:	<input type="checkbox"/> EMR	<input type="checkbox"/> EMT-B	<input type="checkbox"/> EMT-I	<input type="checkbox"/> EMT-P
Certification Number:				
Expiration Date:				
Give Dates, Location & Instructors Last Certification Courses:				
1.				
2.				
3.				
4.				
If Not in Office of Emergency Medical Service in Hartford, Connecticut, Which State.			Certification Number:	

## HEALTH HISTORY

Do You Have Any Physical, Mental or Medical Impairments Which Would Interfere With Your Ability to Perform the Job for Which You Have Applied? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, Please Explain:	
Date of Last Physical Exam	Name & Address of Physician:

## Miscellaneous

Drivers License No.	State:	Type:
Expiration Date:	Restrictions:	
Car Registration:	Insurance Carrier:	Policy No.:
Have You Ever Been Convicted of a Crime, Felony or Misdemeanor? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, Please State:		

## AVAILABILITY

Days: <input type="checkbox"/> NO <input type="checkbox"/> YES	Evenings: <input type="checkbox"/> NO <input type="checkbox"/> YES	Nights: <input type="checkbox"/> NO <input type="checkbox"/> YES
Weekends: <input type="checkbox"/> NO <input type="checkbox"/> YES	Holidays: <input type="checkbox"/> NO <input type="checkbox"/> YES	

## WORK HISTORY

List Your Work History with the Most Recent Employment First. Include Volunteer Work Experience which relates to the Type of Work for Which You Are Applying.		
MAY WE CONTACT YOUR CURRENT EMPLOYER? <input type="checkbox"/> NO <input type="checkbox"/> YES		
Name & Address of Current or Last Employer:		
From: (Month/Year) :	To: (Month/Year)	Title:
Duties:	Reason for Leaving:	
Immediate Supervisor:	Phone: (      )	
Name & Address of Current or Last Employer:		
From: (Month/Year) :	To: (Month/Year)	Title:
Duties:	Reason for Leaving:	
Immediate Supervisor:	Phone: (      )	

## References: List 3 References Other Than Relatives

Name:	Occupation:	Yrs. Known:	Address:	Phone:

I CERTIFY THAT THE ANSWERS ON THIS APPLICATION ARE COMPLETE AND TRUE. FORMER EMPLOYERS AND REFERENCES ARE AUTHORIZED TO FURNISH INFORMATION CONCERNING ME, AND ARE RELEASED FROM ANY LIABILITY FOR ANY DAMAGE DONE WHATSOEVER FOR ISSUING SUCH INFORMATION. I AUTHORIZE INFORMATION TO BE CHECKED AGAINST CONNECTICUT DEPARTMENT OF MOTOR VEHICLES AND OFFICE OF EMERGENCY MEDICAL SERVICE RECORDS. I REALIZE FALSIFICATION OR OMISSION OF ANY INFORMATION ON THIS APPLICATION OR DURING ANY INTERVIEW, RECEIPT OF A POOR REFERENCE, OR FAILURE TO SUCCESSFULLY COMPLETE A PHYSICAL EXAMINATION AT ANY TIME MAY BE CAUSE FOR MY REJECTION OR DISMISSAL. I WILL SUBMIT TO ANY PHYSICAL EXAMINATION REQUIRED AT ANY TIME BY HADDAM'S AMBULANCE SERVICE, INC. IF EMPLOYED, I AGREE TO OBSERVE AT ALL TIMES ALL COMPANY RULES AND REGULATIONS. I UNDERSTAND THAT I MAY BE TRANSFERRED TO ANOTHER ASSIGNMENT AND/OR A DIFFERENT SHIFT DUE TO STAFFING OR CALL VOLUME AND I ACKNOWLEDGE THAT THIS MAY BE A CONDITION OF MY EMPLOYMENT.

It is illegal to make employment decisions based on factors of age, color race, sex, religion, national origin, or disability. As an equal opportunity employee, Haddam Volunteer Ambulance Service, Inc. will sincerely make every effort to recruit and select people for employment on the basis of job related requirements.

Date: _____	Signature of Applicant: _____
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Official Use Only: