



404 Ontario Street  
Fulton, NY 13069  
www.menteramb.com

# EMPLOYMENT APPLICATION

## PERSONAL INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME
MAILING ADDRESS				
CITY		STATE		ZIP CODE
PRIMARY TELEPHONE		ALTERNATE CONTACT NUMBER		E MAIL

## POSITION REQUESTED

- Paramedic                       Critical Care Technician                       AEMT                       Communications Specialist  
 EMT-B                                       EMT Academy Intern                       EMS Instructor

## JOB STATUS REQUESTED

- Full Time       Part-Time       Per Diem                      Date You Can Start: \_\_\_\_\_

Are you currently employed?  YES       NO

## PLEASE MARK THE DAYS YOU ARE AVAILABLE TO WORK

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime	<input type="checkbox"/> Daytime
<input type="checkbox"/> Nights	<input type="checkbox"/> Nights	<input type="checkbox"/> Nights	<input type="checkbox"/> Nights	<input type="checkbox"/> Nights	<input type="checkbox"/> Nights	<input type="checkbox"/> Nights
<input type="checkbox"/> Not available	<input type="checkbox"/> Not available	<input type="checkbox"/> Not available	<input type="checkbox"/> Not available	<input type="checkbox"/> Not available	<input type="checkbox"/> Not available	<input type="checkbox"/> Not available

MAY WE CONTACT YOUR PRESENT EMPLOYER?  YES       NO

If no, state why you do not want us to contact your current employer.

---

Have you ever completed an application with us before?  YES       NO                      IF YES, WHEN \_\_\_\_\_  
Date

Were you referred by one of our current staff members?  YES       NO

Employee Name: \_\_\_\_\_

***Menter Ambulance is an equal opportunity employer.***

**EMERGENCY MEDICAL SERVICES TRAINING AND CERTIFICATIONS**  Not Applicable

CURRENT NYS EMS CERTIFICATION LEVEL	NYS CERTIFICATION NUMBER	CERTIFICATION EXPIRATION DATE	
LOCATION OF INITIAL BASIC EMT TRAINING	DATES PROGRAM ATTENDED	DATE COMPLETED	INSTRUCTOR NAME
LOCATION OF INITIAL ADVANCED TRAINING	DATES PROGRAM ATTENDED	DATE COMPLETED	INSTRUCTOR NAME
LOCATION OF YOUR MOST RECENT CERTIFICATION	DATES PROGRAM ATTENDED	DATE COMPLETED	INSTRUCTOR NAME

OTHER CERTIFICATIONS – LIST ALL OTHER EMS CERTIFICATIONS PERTINENT TO THIS APPLICATION.

TITLE OF CERTIFICATION	DATE AQUIRED	EXPIRATION DATE	LOCATION OF PROGRAM	INSTRUCTOR

**DRIVING EXPERIENCE**

DO YOU HAVE A VALID NEW YORK STATE DRIVER'S LICENSE?  YES  NO How many years have you actively been driving \_\_\_\_\_ years

LICENSE ID NUMBER	ISSUING STATE	LICENSE RESTRICTIONS
DATE YOUR LICENSE WAS FIRST ISSUED	EXPIRATION DATE	LICENSE CLASS & ENDORSEMENTS

LIST **ALL** ACCIDENTS, VIOLATIONS AND/OR SUSPENSIONS THAT YOU HAVE INCURRED DURING THE 40 MONTHS PRIOR TO THE DATE OF THIS APPLICATION. ATTACH AN ADDITIONAL SHEET IF NEEDED.

DATE	ACCIDENT / VIOLATION	CIRCUMSTANCES	POINTS

LIST ANY DRIVER TRAINING PROGRAMS OR POINT REDUCTION PROGRAMS ATTENDED DURING THE 36 MONTHS PRIOR TO THE DATE OF THIS APPLICATION.

DATE	PROGRAM	LOCATION	INSTRUCTOR	POINTS REDUCED

DO YOU HAVE AMBULANCE DRIVING EXPERIENCE?  YES  NO

IF YES, ANSWER THE FOLLOWING:

AMBULANCE TYPE  Type II  Type III

APPROXIMATE NUMBER OF HOURS: \_\_\_\_\_

WERE YOU GIVEN FORMAL DRIVER TRAINING?  YES  NO

IF YES, HOW MANY HOURS: \_\_\_\_\_

## FORMAL EDUCATION

LIST ALL SCHOOLS ATTENDED. PLEASE PROVIDE COMPLETE INFORMATION.

SCHOOL NAME	ADDRESS	DATES ATTENDED (MM/YY)	DATE GRADUATED (MM/YY)
ELEMENTARY			
MIDDLE SCHOOL			
HIGH SCHOOL			
COLLEGE			DEGREE/MAJOR
COLLEGE			DEGREE/MAJOR

## EMPLOYMENT HISTORY

WE REVIEW THE DETAILED WORK HISTORY OF ALL APPLICANTS. LIST ALL OF YOUR PREVIOUS EMPLOYERS CHRONOLOGICALLY.

DATES (MM/YY)	NAME OF EMPLOYER COMPLETE ADDRESS & PHONE NUMBER	JOB HELD SUPERVISOR'S NAME	REASON FOR LEAVING	HOURLY WAGES

## NON-JOB RELATED EMS AFFILIATIONS & EXPERIENCE

WE EVALUATE ALL PREVIOUS EMS EXPERIENCE WHEN REVIEWING AN APPLICANT FOR EMPLOYMENT CONSIDERATION. LIST ALL EMS AGENCIES AND EXPERIENCES THAT WERE NOT EMPLOYMENT RELATED (VOLUNTEER).

DATES OF MEMBERSHIP	NAME OF ORGANIZATION COMPLETE ADDRESS & PHONE NUMBER	NAME OF CHIEF OFFICER	DUTIES POSITIONS HELD	REASON FOR LEAVING

## PERSONAL REFERENCES

AS PART OF OUR PRE-EMPLOYMENT SCREENING, MENTER AMBULANCE MAY INTERVIEW PERSONS FROM PRIOR WORK EXPERIENCE AS WELL AS PERSONAL REFERENCES SUPPLIED BY THE APPLICANT. PLEASE PROVIDE THREE PERSONAL REFERENCES THAT ARE NOT RELATED TO YOU.

NAME	MAILING ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

- Please be advised you can mail your application to us via USPS at **Menter Ambulance c/o Human Resources 404 Ontario St. Fulton, NY 13069** or you can fax it Attn: HR Dept. at **315-598-7017** (please allow apx. 2 weeks for processing)

**APPLICANT’S STATEMENT**

I hereby certify that all information provided is true and complete to the best of my knowledge. I authorize the investigation and verification of all information, statements and references which I have furnished. I further authorize Menter Ambulance to use this information in formulating its decision to make, or not make, an offer of employment.

In the event an employment offer is made, based on the information provided, I understand that any omission of fact, false or misleading information discovered now or in the future may result in my being terminated from employment. Also, I understand that by accepting employment, I agree to abide by, and follow, all rules, regulations, policies, procedures and job requirements set by Menter Ambulance and that failure to follow such rules and regulations shall be grounds for termination of my employment.

APPLICANT’S SIGNATURE	DATE
-----------------------	------

**STAFF DEVELOPMENT USE ONLY**

DATE APPLICATION RECEIVED		INITIALS	REFERENCES MAILED ON		INITIALS	INTERVIEW CONDUCTED BY	DATE
FOLLOW UP INTERVIEW BY	DATE	FOLLOW UP INTERVIEW BY	DATE	APPLICATION REVIEW MEETING DATE		INITIALS	
APPLICATION APPROVED	APPLICATION REJECTED	REASON					