



# Application for Employment Hamilton County Ambulance

*An Affirmative Action/Equal Opportunity Employer  
Subject to a Veteran's Preference*

NAME-LAST	FIRST	INITIAL	TELEPHONE NUMBER ( )
ADDRESS			SOCIAL SECURITY NUMBER
CITY		STATE	ZIP CODE
POSITION(S) DESIRED: 1. _____ 2. _____		HOW DID YOU BECOME INTERESTED IN HAMILTON COUNTY AMBULANCE?	

HOURS AVAILABLE TO WORK <input type="checkbox"/> PART-TIME - # hrs per week _____ <input type="checkbox"/> FULL TIME <input type="checkbox"/> SUMMER <input type="checkbox"/> PERDIEM	INDICATE SHIFT <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> NIGHT	ARE YOU AVAILABLE TO WORK WEEKENDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU A VETERAN? * <input type="checkbox"/> YES <input type="checkbox"/> NO
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\*This position is subject to a veteran's preference. A veteran requesting preference must submit with his/her application for employment a copy of the veteran's Department of Defense Form 214. A spouse of a veteran requesting preference must submit with his/her application for employment a copy of the veteran's Department of Defense Form 214, a copy of the veteran's disability verification from the United States Department of Veteran Affairs demonstrating a 100 percent permanent disability rating, and proof of marriage to the veteran.

WHAT DATE WOULD YOU BE AVAILABLE FOR WORK?	SALARY REQUESTED?
HAVE YOU EVER BEEN EMPLOYED WITH HAMILTON COUNTY? <input type="checkbox"/> NO <input type="checkbox"/> YES, PROVIDE TITLE AND YEARS OF SERVICE.	HAVE YOU FILED AN APPLICATION HERE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES, WHEN WAS LAST APPLICATION FILED? _____
ARE YOU OVER 18 YEARS OF AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

IF YOU ARE HIRED, ARE YOU ABLE TO PRESENT PROOF OF LEGAL AUTHORIZATION TO WORK IN THE UNITED STATES?  
 YES     NO    IF "NO" EXPLAIN WHAT TYPE OF VISA

HAVE YOU EVER BEEN CONVICTED OF A FELONY?  
 YES     NO    IF "YES" PLEASE EXPLAIN

NAME AND ADDRESS OF SCHOOLS ATTENDED	ACADEMIC MAJOR	LIST DIPLOMA OR DEGREE
HIGH SCHOOL OR VOCATIONAL SCHOOL		
EMT COLLEGE		
COLLEGES OR UNIVERSITIES		
GRADUATE SCHOOL/OTHER		

LIST CLINICAL EXPERTISE OR CERTIFICATION <input type="checkbox"/> CPR <input type="checkbox"/> PALS/PEPP <input type="checkbox"/> ACLS <input type="checkbox"/> EMT <input type="checkbox"/> EVOC <input type="checkbox"/> AEMT <input type="checkbox"/> PHTLS <input type="checkbox"/> PARAMEDIC	OTHER FORMAL TRAINING (Include Medical Classes) <input type="checkbox"/> _____ <input type="checkbox"/> WORD PROCESSING/COMPUTER EXPERIENCE <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> OTHER SKILLS (Specify) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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ARE YOU NOW LICENSED, CERTIFIED OR REGISTERED IN YOUR OCCUPATION?     YES     NO                      IN NEBRASKA?     YES     NO

NEBRASKA LICENSE, CERTIFICATION OR REGISTRATION NUMBER \_\_\_\_\_                      EXPIRATION DATE \_\_\_\_\_

IF NOT LICENSED, CERTIFIED OR REGISTERED IN NEBRASKA, HAVE YOU MADE APPLICATION?     YES     NO                      VERIFIED \_\_\_\_\_  
 EXPLAIN \_\_\_\_\_

DOES THE LICENSING BOARD HAVE ANY COMPLAINTS ON FILE IN REGARDS TO YOU LICENSE/CERTIFICATION/REGISTRATION?     YES     NO  
 IF YES, PLEASE EXPLAIN \_\_\_\_\_

May we contact your present employer: Yes \_\_\_\_\_ No \_\_\_\_\_

List most recent employer first (include volunteer work). Please complete in full even though you may have a resume.

<b>Dates Employed</b>		Employer: _____	Title: _____
From _____	To _____	Address: _____	Duties: _____
		City, State: _____	
<b>Salary</b>		Immediate Supervisor: _____	
From _____	To _____	Phone Number: (_____) _____	
		Reason for Leaving: _____	

<b>Dates Employed</b>		Employer: _____	Title: _____
From _____	To _____	Address: _____	Duties: _____
		City, State: _____	
<b>Salary</b>		Immediate Supervisor: _____	
From _____	To _____	Phone Number: (_____) _____	
		Reason for Leaving: _____	

<b>Dates Employed</b>		Employer: _____	Title: _____
From _____	To _____	Address: _____	Duties: _____
		City, State: _____	
<b>Salary</b>		Immediate Supervisor: _____	
From _____	To _____	Phone Number: (_____) _____	
		Reason for Leaving: _____	

<b>Dates Employed</b>		Employer: _____	Title: _____
From _____	To _____	Address: _____	Duties: _____
		City, State: _____	
<b>Salary</b>		Immediate Supervisor: _____	
From _____	To _____	Phone Number: (_____) _____	
		Reason for Leaving: _____	

**Professional or Academic Referral:** (Do not give name of relative or former employer)

Name	Address & Telephone Number	Occupation	Years Known
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I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that Hamilton County shall not be liable in any respect if my employment is terminated because of the falsity of statements, answers or omissions made by me in this questionnaire. I authorize the companies, schools or persons named to give any information regarding my employment, together with any information they may have regarding me. Employment, if offered, is for an indefinite time period and is at-will. I hereby release said companies, schools or persons from all liability for any damage for issuing this information. In addition, if accepted for employment, I hereby agree to abide by the rules and policies of my employer. Employment is contingent upon satisfactory completion of pre-employment immunization screening, and background check, if applicable.

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

**FOR HUMAN RESOURCES USE ONLY**

JOB TITLE		DEPT. #	<input type="checkbox"/> FT <input type="checkbox"/> PT    # HRS. PER PAY PERIOD _____		SHIFT 1    2    3	PE SCREEN
						BENEFITS
GRADE	CODE	DATE OF HIRE	REVIEW DATE	SHIFT	START TIME	SALARY
DEPARTMENT HEAD SIGNATURE					DATE	