CLOVERDALE HEALTH CARE DISTRICT AMBULANCE

EMPLOYMENT APPLICATION

NAME:_____ SSN:_____

ADDRESS: DL#:_____

_____ HOME PH:_____

_____ CELL PH: _____

_____ WORK PH: _____

POSITION
DESIRED:_____

FULL TIME □ PART TIME □ BACK UP □ DATE AVAILABLE:_____

EDUCATION

LEVEL	SCHOOL NAME / LOCATION	YEAR GRAD	SUBJECTS / DEGREE / CERT.
HIGH SCHOOL			
COLLEGE			
OTHER SCHOOLS			

FORMER EMPLOYERS (LIST YOUR LAST 4 EMPLOYERS, STARTING WITH THE MOST RECENT FIRST)

DATE MONTH / YEAR	EMPLOYER NAME AND ADDRESS	POSITION	SALARY	REASON FOR LEAVING
FROM: **TO:**				
FROM: **TO:**				
FROM: **TO:**				
FROM: **TO:**				

REFERENCES PLEASE LIST IN THE FOLLOWING BOX THREE PEOPLE NOT RELATED TO YOU AND WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR.

NAME	ADDRESS	PHONE	YEARS KNOWN

EXPERIENCE PLEASE DESCRIBE BELOW ANY SKILLS OR ADDITIONAL QUALIFICATIONS

GENERAL INFORMATION

DO YOU SPEAK ANY FOREIGN LANGUAGES? YES □ NO □ _____

HAVE YOU EVER WORKED FOR AN EMPLOYER WHO PROVIDED PUBLIC EMPLOYEE RETIREMENT (PERS) BENEFITS? YES □ NO □ IF YES, GIVE NAME, ADDRESS, AND PHONE NUMBER

_____

DO YOU HAVE ANY PHYSICAL LIMITATIONS OR DISABILITIES THAT COULD PREVENT YOU FROM PERFORMING THE DUTIES ASSOCIATED WITH THIS POSITION? YES □ NO □ IF YES, PLEASE EXPLAIN:_____

ADDITIONAL COMMENTS

IN CASE OF EMERGENCY, PLEASE NOTIFY:

_____PHONE:_____

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION, FALSIFICATION OR OMISSION OF FACTS CALLED FOR IS CAUSE FOR DISMISSAL. FURTHER, I UNDERSTAND THAT THE USE OF THIS FORM DOES NOT INDICATE THERE ARE ANY POSITIONS OPEN AND DOES NOT IN ANY WAY OBLIGATE THIS AGENCY.

SIGNATURE:_____**DATE:**_____

DO NOT WRITE BELOW THIS LINE

DATE OF HIRE:_____ POSITION:_____

STARTING PAY SCHEDULE:_____ AMOUNT:_____EMPLOYEE NUMBER:_____

APPROVED:_____
ADMINISTRATOR