

GALENA EMERGENCY MEDICAL SERVICES
217 SUMMIT STREET
GALENA, IL 61036



APPLICATION FOR MEMBERSHIP

PERSONAL INFORMATION

FIRST NAME MIDDLE INITIAL LAST NAME

HOME ADDRESS CITY STATE ZIP

DATE OF BIRTH SOCIAL SECURITY# DRIVERS LICENSE#

HOME TELEPHONE NUMBER CONTACT TELEPHONE NUMBER EMAIL ADDRESS

POSITION APPLYING FOR DRIVER EMT EMR

EMPLOYMENT INFORMATION
CURRENT EMPLOYER NAME OF IMMEDIATE SUPERVISOR

OCCUPATION YEARS EMPLOYED HOURS OF EMPLOYMENT

EMPLOYERS ADDRESS CITY STATE ZIP TELEPHONE#

PREVIOUS EMPLOYER NAME OF IMMEDIATE SUPERVISOR

EMPLOYERS ADDRESS CITY STATE ZIP TELEPHONE#

I can respond to Weekday calls ____ Night Calls ____ Weekend Calls ____

EDUCATION AND EXPERIENCE

EDUCATION: HIGHEST GRADE COMPLETED 10 11 12 13 14 15 16 16+

GED HIGH SCHOOL DIPLOMA DEGREE(\$)_____

DO YOU HAVE PREVIOUS EMS EXPERIENCE? YES .NO

IF YES, WHERE, PROVIDE LOCATION AND DATES OF SERVICE

ARE YOU CURRENTLY LICENSE WITH THE IDPH YES NO

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO

REFERENCES

LIST TWO CHARACTER REFERENCES, OTHER THAN YOUR SPOUSE OR RELATIVES

NAME ADDRESS TELEPHONE#

NAME ADDRESS TELEPHONE#

PLEASE EXPLAIN WHY YOU ARE CHOOSING TO BECOME A MEMBER OF GALENA EMS

ACKNOWLEDGEMENT

IF THIS APPLICATION IS GRANTED, I PROMISE FULL AND FAITHFUL OBSERVANCE OF ALL OF THE LAWS, RULES, POLICIES, AND PROTOCOLS THAT GOVERN GALENA AREA EMERGENCY MEDICAL SERVICES DISTRICT. I WILL PRESENT A COMPLETED PHYSICAL EXAMINATION AND DRUG SCREEN REPORT PRIOR TO ACTIVELY PARTICIPATING IN ANY DISTRICT FUNCTIONS

SIGNED BY MY OWN HAND ON THIS _____ DAY OF _____, 20____

APPLICANT
SIGNATURE: _____

ENDORSEMENT

THIS CANDIDATE IS BEING ENDORSED BY:

AS AN EMS MEMBER, YOU HAVE A RESPONSIBILITY TO EXERCISE EVERY PRECAUTION IN SELECTING GALENA EMS MEMBERS. THEREFORE, WE WOULD APPRECIATE YOUR OPINION AS TO THE CHARACTER AND REUABILTY OF THIS INDIVIDUAL, AS WELL AS INFORMATION ON HIS/HER EMPLOYMENT AND CRIMINAL HISTORY. THE INFORMATION THAT YOU PROVIDE WILL BE HELD IN CONFIDENCE.

To assist us in our recruiting effort, please indicate how you heard about us:				
Brochure	Newspaper	EMS Member	Friend	Other _____

Received by: EMS Director _____ Date: _____

EMT President, _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the Galena Area Emergency Medical Service District to engage in a background investigation including criminal history and further authorize all former employers to furnish any information concerning my background. I understand that the information gathered will be provided to the appropriate Galena Area Emergency Medical Service District staff members for review and consideration.

I release the Galena Area Emergency Service District, their agents and employees from all liability in connection with this review and use of the information presented.

Applicant Signature _____ Date _____

Applicant (Print Clear) _____