



# WHITEMARSH COMMUNITY AMBULANCE ASSOCIATION

SERVING WHITEMARSH TOWNSHIP SINCE 1956

## Personal Information

**Date of Application:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last Name                      Suffix                      First Name                      Middle Name

**Address:** \_\_\_\_\_  
Street                                      City                                      State                                      Zip Code

**Telephone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Alternate Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Email:** \_\_\_\_\_ @ \_\_\_\_\_

**Social Security Number\*:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*\*Note: All healthcare entities are required to register providers by their Social Security Number to Medicare.*

**Driver's License Number:** \_\_\_\_\_  
**State:** \_\_\_\_\_                      **Expiration Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Applicant Questions:

Are you at least 21 years of age or older?    Yes    /    No

If under 18, do you have a work permit?    Yes    /    No

How did you find out about this position?    Yes    /    No

Do you have any relatives or friends working/volunteering here?    Yes    /    No

If yes, please list the names: \_\_\_\_\_  
\_\_\_\_\_



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## Position Information

Position applying for or type of work desired?: \_\_\_\_\_

*Full Time*

*Part Time*

*Volunteer*

Have you previously been or applied to be an employee/volunteer for at WCAA? \_\_\_\_\_

If yes, please list the date(s), prior position(s), and reason(s) for leaving: \_\_\_\_\_

## Work Requirements & General Information

Can you provide, if accepted for volunteer membership/employment, that you are eligible to work in the U.S.? Yes / No

Do you have a valid driver's license? Yes / No

Has your driver's license ever been suspended or revoked for any reason? Yes / No

If yes, please list the date(s) and reason(s): \_\_\_\_\_

Have you ever been arrested, charged, or convicted by any law enforcement authority or court?

If yes, please explain all such events including place(s), date(s), and disposition(s):

Have any of your medical certifications or Medicare Provider Privileges been suspended or revoked?:

If yes, please explain all such events including place(s), date(s), and disposition(s):

*\*Note: Answering "yes" to any of the above questions does not constitute an automatic rejection from membership/employment. Date of the offence, serious and nature of the violation, rehabilitation, and position applied for will be considered.*

4019 Joshua Road, Lafayette Hill PA, 19444  
Phone: (610) 828-0955 Fax: (610) 834-7454



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## Certification Information

	Number	Activation Date	Expiration Date	Certifying Agency	Included
<b>Required:</b>					
CPR					
PA EMS Provider Certification					
EVOC/EMSVO					
NIMS ICS 100					
NIMS ICS 200					
NIMS ICS 700					
NIMS ICS 800					
ACLS (Medics Only)					
PALS (Medics Only)					
<b>Preferred:</b>					
PHTLS/TCCC					

## Employment History

List your last three employers or volunteer activities starting with the most recent.

Employer: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
 Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Salary: \_\_\_\_\_  
 Job Description: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Reason for leaving: \_\_\_\_\_  
 Contact Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ May we contact?: Yes / No

Employer: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
 Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Salary: \_\_\_\_\_  
 Job Description: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Reason for leaving: \_\_\_\_\_  
 Contact Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ May we contact?: Yes / No



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## Employment History (Continued)

Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Salary: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Contact Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ May we contact?: Yes / No

Please any gaps in employment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Military Service

None

Army

Navy

Air Force

Marines

Coast Guard

Date Entered: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Departed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Rank: \_\_\_\_\_

Discharge Status: \_\_\_\_\_ Location: \_\_\_\_\_

## Additional Job-Related Qualifications

List any work-related training, skills, certifications, licenses, and/or other qualifications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any additional qualifications or information, personal or professional, that you feel that would be beneficial for us to know when considering your application:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any EMS/Fire/Professional Affiliations (other than listed under prior employment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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# WHITEMARSH COMMUNITY AMBULANCE ASSOCIATION

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## Educational / Vocational History

High School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Years Completed: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you graduate: Yes / No GED Received?: Yes / No

College Name: \_\_\_\_\_

Address: \_\_\_\_\_

Years Completed: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you graduate: Yes / No Degree / Certification Received: \_\_\_\_\_

College Name: \_\_\_\_\_

Address: \_\_\_\_\_

Years Completed: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you graduate: Yes / No Degree / Certification Received: \_\_\_\_\_

Technical School: \_\_\_\_\_

Address: \_\_\_\_\_

Years Completed: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you graduate: Yes / No Degree / Certification Received: \_\_\_\_\_

Other School/Training: \_\_\_\_\_

Address: \_\_\_\_\_

Years Completed: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you graduate: Yes / No Degree / Certification Received: \_\_\_\_\_

## References

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Years Known: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Years Known: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Years Known: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_



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## ACKNOWLEDGEMENT

I certify that the information I have given on this application is true, complete, and correct, and I understand that any false information or the omission of information may be considered as sufficient reason for my discharge if hired. I recognize that completion of this application does not mean that job openings exist and does not obligate the company in any way. Applications will remain active for six months, after which time re-application will be necessary. If hired, employment will be “at will” and either I or the company is free to terminate the employment relationship at any time without cause and without prior notice. This application is no an agreement or a contract for employment.

If offered a position and at any time thereafter, I consent to medical examinations as may be requested to determine my fitness to perform the job duties.

I understand that I may be requested to undergo drug-screening tests as a condition of employment. To comply with this requirement, I consent to providing a sample of my urine or other physical samples (such as blood or hair) prior to employment and again at any time so requested. Specimens will be tested for both legal (prescription drugs) and illegal substances. A positive test for legal substances will require proof of a current prescription. At this time, WCAA’s policy does not permit the use of marijuana, in any form, even with proof of a current prescription. I further consent to allow any doctor, hospital, or testing laboratory to conduct any medical test or examination as may be required by the company as a condition of my employment, and I hereby give my consent to the release of all information which the company deems necessary to determine my ability to perform job duties now or in the future.

I further understand that refusal to submit to an alcohol or drug screen test at any time will result in immediate discharge from this company.

I hereby authorize the company to investigate my employment history with former employers and to make any further investigation deemed necessary in connection with my application for employment, including a criminal history check, driving history check, child abuse clearance check, credit history, and other such inquiries. I release the company and all informants from all liability resulting from such inquiries. I waive all rights to see or review the information so furnished.

I certify that I am not now, nor have I ever been excluded from any state or federal health care program. I further understand that if it is determined that I was so excluded, my employment with the company may be terminated.

Applicant’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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