

**BOROUGH OF BUENA EMERGENCY MEDICAL SERVICES DEPARTMENT**

**Employment Application**

---

The Borough of Buena EMS Department is an Equal Opportunity Employer Operating under the New Jersey Department of Personnel and an Established Affirmative Action Program. All applicants are considered for positions without regard to race, creed, color, national origin, nationality, ancestry, sex/gender, civil union status, domestic partnership status, affectional or sexual orientation, genetic information, pregnancy, gender identity or expressions, disability (actual or perceived) age, marital status, familial status, religion, atypical hereditary or cellular or blood trait, of any individual or because of liability for service in the armed forces of the United States or because of refusal to submit to genetic test or make available the results of a genetic test to an employer.

Please follow these instructions when completing this application:

1. Please print legibly in ink.
2. This application must be fully completed. A resume may be included; however, it will not substitute for the application or any section within this application. Any incomplete applications will not be considered.
3. Photocopies of the following documents must be included with this application. Failure to include the minimum documents will automatically reject your application.
  - a. EMT-B/NREMIT-B certification.
  - b. Valid CPR Certification.
  - c. Valid New Jersey Drivers License

**Administration Use Only**

Application Received: \_\_\_\_\_ Reference Check: \_\_\_\_\_

All Attachments Included: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Applicant Contacted: \_\_\_\_\_ Pay Rate: \_\_\_\_\_

Applicant Interviewed: \_\_\_\_\_ Start Date: \_\_\_\_\_

By Whom: \_\_\_\_\_

**BOROUGH OF BUENA EMERGENCY MEDICAL SERVICES DEPARTMENT**

**ACKNOWLEDGMENT**

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 Department in any way. Applications will remain active for six months, after which time re-application will be necessary. This application is not an agreement or a contract for employment.

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

I understand that I may be required 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. I further consent to allow any doctor, hospital or testing laboratory to conduct any medical test or examination as maybe required by the Department as a condition of my employment, and I hereby give my consent to the release of all information which the Department 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 may result in immediate discharge from this Department. I hereby authorize the Department 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, and other such inquiries. I release the Department and all informants from all liability resulting from such inquiries. I certify that I am not now, nor have I ever been excluded from any state or federal health care program or EMT related service. I further understand that if it is determined that I was so excluded; my employment with the Department may be terminated.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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



Can you work any Assigned Shift? YES \_\_\_\_\_ NO \_\_\_\_\_

Can you work? Overtime \_\_\_\_\_ Nights \_\_\_\_\_ Weekends \_\_\_\_\_ Holidays \_\_\_\_\_

Please explain your availability:

---

Are you a citizen of the United States? YES \_\_\_ NO \_\_\_

If no, are you authorized to work in the U.S.? YES \_\_\_ NO \_\_\_

Have you ever worked for the Borough of Buena? YES \_\_\_ NO \_\_\_

If yes, when? \_\_\_\_\_

Are you over 18 Years old? YES \_\_\_ NO \_\_\_

### **EDUCATION**

High School: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Did you graduate? YES \_\_\_ NO \_\_\_

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

From: \_\_\_\_\_ To: \_\_\_\_\_

Did you graduate? YES \_\_\_ NO \_\_\_ Degree: \_\_\_\_\_

Post College Education? YES \_\_\_\_\_ NO \_\_\_\_\_

Name of Institution: \_\_\_\_\_

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

Degree: \_\_\_\_\_

## REFERENCES

Please list three professional references unrelated to you whom we may contact for information concerning your qualifications.

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Previous Employment**

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

May we contact your previous supervisor for a reference? Yes \_\_\_\_\_ No \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

May we contact your previous supervisor for a reference? Yes \_\_\_\_\_ No \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

May we contact your previous supervisor for a reference? Yes \_\_\_\_\_ No \_\_\_\_\_

**Military Service**

Branch: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Rank at Discharge: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

If other than Honorable, please explain: \_\_\_\_\_

**Certifications/EMS Experience**

EMT or NREMT Cert #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Date:

Initial Certification Date: \_\_\_\_\_

Current Re/Certification Date : \_\_\_\_\_

Certification Level: \_\_\_\_\_

CPR Expiration Date: \_\_\_\_\_

Total amount of time working in a 911 based agency.  
(months/years): \_\_\_\_\_

Total amount of time Volunteering in a 911 based agency.  
(months/years): \_\_\_\_\_

Total amount of time working in a medical transport- based agency.  
(months/years): \_\_\_\_\_

1.CEVO: Yes or No

2.Incident Command 100: Yes or No

3.Incident Command 200: Yes or No

4.NIMS 700: Yes or No

5.NIMS 800: Yes or No

6.Hazmat Awareness: Yes or No

7.Weapons of Mass Destruction / CBRNE Awareness: Yes or No

8. Developmental Disabilities: Yes or No

If you have any other certifications, please list in the space provided.



**Other Certifications and/or Specialized Training**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**EMS Skills Summary (indicate which of the following skills you have performed in the past year)**

- Airway: Oral \_\_\_\_\_
- Assist Medication Admin: Oral \_\_\_\_\_
- Stretcher: Ambulance \_\_\_\_\_
- Airway: Nasal \_\_\_\_\_
- Assist Medication Admin: SL \_\_\_\_\_
- Stretcher: Chair \_\_\_\_\_
- Defibrillation: Automatic \_\_\_\_\_
- Oxygen Administration \_\_\_\_\_
- Traction Splint \_\_\_\_\_
- Childbirth \_\_\_\_\_
- Glucose \_\_\_\_\_
- Extrication Spinal Immobilization: Short \_\_\_\_\_
- Decontamination \_\_\_\_\_
- Ambulance Driving \_\_\_\_\_
- Extrication Spinal Immobilization: Long \_\_\_\_\_
- Naloxone Admin. (NARCAN) \_\_\_\_\_
- Dispatching \_\_\_\_\_
- Splinting \_\_\_\_\_
- Epi -Pen Administration \_\_\_\_\_
- Triage \_\_\_\_\_
- Fracture Management \_\_\_\_\_

**Additional Information That Would be Helpful in Evaluating your Qualifications**

---

---

---

Has your EMT certification ever been suspended or revoked? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please explain \_\_\_\_\_

Do you currently have an EMT certification in any other state? If so, please provide the EMT Level, Certification Number and Expiration date.

---

### Supplemental Driving Application

1. a) Do you hold a valid driver's license? YES \_\_\_ NO \_\_\_  
b) License No.: \_\_\_\_\_ State: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
c) If you answered no to 1(a), what date will you obtain your license?  
\_\_\_\_\_
  
2. a) Do you have a CDL license? YES \_\_\_ NO \_\_\_  
b) License No.: \_\_\_\_\_ State: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_
  
3. a) Have you held a license in any other state in the past five (5) years from the date of this application? YES \_\_\_ NO \_\_\_  
b) If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
4. a) Have you ever been denied a license, permit, or privilege to operate a motor vehicle in New Jersey or any other state? YES \_\_\_ NO \_\_\_  
b) If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
  
5. a) Do you presently hold more than one valid driver's license?  
YES \_\_\_ NO \_\_\_  
b) If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
  
6. a) Have you ever been disqualified as a driver under the Federal Motor Vehicle Carrier Safety Standards? YES \_\_\_ NO \_\_\_  
b) If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant's Authorization**

I, \_\_\_\_\_ (Print your Name) authorize the Borough of Buena to run an MVR Report.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicant's Certification**

I, \_\_\_\_\_ (Print Your Name) hereby certify that, to the best of my knowledge and belief the answers to the questions I have given on this supplemental driving application and the facts that I have supplied are true and complete. I am aware that if I have given false, misleading or incomplete answers or facts in this application, my application will be rejected and the, if I am Employed, any such falsification, misleading or incomplete answers or facts supplied herein shall be a basis for termination of my employment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTARIZATION

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, \_\_\_\_\_  
signed the above

Release of Liability in my presence.

**NOTARY PUBLIC**

Residing at: \_\_\_\_\_

My Commission expires: \_\_\_\_\_

Signature: \_\_\_\_\_