

Dear Applicant,

Thank you for applying to American Heritage Ambulance Service, LLC.

American Heritage Ambulance is a private transport company. We serve multiple vendors. Those vendors require American Heritage Ambulance to complete National Background checks to ensure the safety and well being of the patients we transport.

In order for American Heritage Ambulance to meet the request of our vendors we reserve the right to refuse employment to any individual that has ever been convicted for substance abuse, a crime of a sexual nature, crime of violence or any felony.

The follow items are required to complete the application process.

- 1. Completed Application**
- 2. Copy of current certifications**
- 3. Copy of valid Driver's License**
- 4. Current 10 year MVR (from the state in which you were licensed in for the greatest part of 10 years)**

National Background certificate (www.Sentrylink.com) will be requested at time of interview. All items must be submitted within 10 days of the completed application in order to be considered for employment with American Heritage Ambulance Service, LLC. Should you have any questions or concerns please contact me direct at 843-824-8447.

Thanks,

**Renee' Hodge
Administrative Assistant
American Heritage Ambulance Service, LLC**



Application for Employment

PERSONAL INFORMATION (PLEASE PRINT or TYPE)

Date	NAME (LAST, FIRST, MIDDLE)	SSN
Street Address		City, State
		Zip
Phone #	Alternate Phone #	Best Time to be Reached

REFERRAL SOURCE

Referral Type <input type="checkbox"/> Walk In <input type="checkbox"/> Advertisement <input type="checkbox"/> Agency <input type="checkbox"/> Employee <input type="checkbox"/> Other:
If Referred by a Current Employee, Please State Name:
If Referred by an Agency or Other, Please State:

Position Desired

Position	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time
* Some positions may require working overtime, weekends, evenings, or holidays; is this acceptable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Minimum Pay Acceptable \$ _____ Per Hour	Date Available	

ELIGIBILITY HISTORY

Are you eligible to work in the United States?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been excluded, debarred, suspended, or otherwise determined to be ineligible to participate as a provider or employee or agent of a provider of health care services associated with any federal, state, local, or private health care insurance program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been convicted of, plead no contest to or been the beneficiary of a plea agreement involving a criminal offense charged against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been employed by American Heritage Ambulance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list any relatives in our employment and your relationship.		
Do you have a contract or agreement with another company that may limit your ability to perform for American Heritage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been known by any other names? If so, please list		

QUALIFICATIONS

Type	Expiration Date	Certification Level	Instructing Agency	Certification Number
EMT				
CPR				
Firefighter				
Other				

PROFESSIONAL COURSES, Etc

Courses:
Special Skills:

EMPLOYMENT RECORD

Company Name:	Supervisor's Name:	Phone:
Street Address:	City, State:	Zip:
Job Title:	Work Performed:	Reason for Leaving:
Date of Employment From: To:	Start Salary \$	Ending Salary \$
May we contact this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Company Name:	Supervisor's Name:	Phone:
Street Address:	City, State:	Zip:
Job Title:	Work Performed:	Reason for Leaving:
Date of Employment From: To:	Start Salary \$	Ending Salary \$
May we contact this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Company Name:	Supervisor's Name:	Phone:
Street Address:	City, State:	Zip:
Job Title:	Work Performed:	Reason for Leaving:
Date of Employment From: To:	Start Salary \$	Ending Salary \$
May we contact this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Company Name:	Supervisor's Name:	Phone:
Street Address:	City, State:	Zip:
Job Title:	Work Performed:	Reason for Leaving:
Date of Employment From: To:	Start Salary \$	Ending Salary \$
May we contact this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EDUCATION- High School

Name:	Location:
Last Year Completed <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION-Graduate School

Name:	Location:
Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No	Degree/Major:

REFERENCES- Work

Name:	Title:
Address:	Telephone:
How long have you known this person:	
Name:	Title:
Address:	Telephone:
How long have you known this person:	

REFERENCES- Personal

Name:	Relationship:
Address:	Telephone:
How long have you known this person:	
Name:	Relationship:
Address:	Telephone:
How long have you known this person:	

National background check must be provided by the applicant. The background may be obtained on-line:
www.Sentrylink.com

S.C. SECOND INJURY FUND QUESTIONNAIRE

For the purposes of fulfilling the requirements of S.C. Code Ann. Section 42-9-400, your employer needs to know if, to the best of your knowledge, you have ever had any of the following conditions:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosis of joints
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hyperinsulinism
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Amputated foot, leg, arm or hand	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Loss of sight of one or both eyes or partial loss of more than 75 percent bilateral	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Metal Poisoning
<input type="checkbox"/>	<input type="checkbox"/>	Residual disability from Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Ionizing Radiation Injury
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Compressed Air sequelae
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Ruptured Disc
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	Brain Damage
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Silicosis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle-cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Psychoneurotic disability following treatment in a recognized medical or mental institution?	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Osteomyelitis
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins

Have you suffered from any other pre-existing disease, condition or impairment which is permanent in nature? (If yes, please explain on the back of this form.)

Do you have any chronic diseases or medical conditions or injuries for which you have received compensation? (If yes, please explain on the back of this form.)

ACKNOWLEDGEMENT AND RECORDS RELEASE

I understand this questionnaire is for the purposes of enabling my employer to fulfill the requirements of the South Carolina Second Injury Fund, and it is in no way connected to the Company's decision to hire me. The information provided is not to be used by the Company as a basis of denying me placement within the Company or promotion, or to discriminate against me in any way. The information provided is true to the best of my information and belief. In the event of a future work related accident, my employer is authorized to request and review medical records pertaining to any of the conditions described herein as well as any records maintained by any government agency, past employer, or treatment facility with respect to any personal injuries I have received.

Signed: _____ **Date:** _____
(Employee's Signature)

Witness: _____ **Date:** _____
(Witness' Signature)



AMERICAN HERITAGE AMBULANCE, LLC

Applicant Consent for Motor Vehicle Report

Date: _____

Driver Full Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

State in which license was issued: _____

License Number: _____

I, _____ give American Heritage Ambulance policy holder permission to run a Motor Vehicle Report on my driver's license and discuss (in detail) the results with American Heritage Ambulance and understand that the use of a company vehicle in the capacity of employment with American Heritage Ambulance may be restricted or prohibited on this information.

Driver's Signature

Date