EMERGENCY MEDICAL TECHNICIAN APPLICATION

MUTUAL AID AMBULANCE EMS - PO Box 350, Greensburg, PA 15601

Mutual Aid Ambulance Training Institute

FALL 2017

Name: _____

Mailing Address: _____

PO Box, Street City State Zip

I am a legal resident of _____

County

Age_____ Date of Birth_____(PA Dept. of Health Recommends Applicants be 18)

Employer's Name _____ Address_____

Occupation _____ EMS related? ( ) Yes ( ) No

Phone Number: Home _____ Cell _____

Work _____

E-mail Address _____

EDUCATION: (Circle highest level completed)

	YRS.
G.E.D	
High School	9 10 11 12
College	1 2 3 4
Graduate School	1 2 3 4

EMERGENCY MEDICAL CARE AFFILIATION:

Indicate type (e.g. Ambulance, Fire Department, E.R., Rescue, Other)

Name of Organization	Location	Phone Number (Non-emergency)	Dates (from - to)
_____	_____	_____	_____
_____	_____	_____	_____

OPTIONAL DATA: ( ) Male ( ) Female Race _____ Handicapped? _____

_____

Signature

(Must be 16 years or older to qualify for state certification examination)

***Participation in a Mutual Aid Ambulance sponsored program does not imply nor guarantee employment.**