



South Central Wyoming  
Emergency Medical Services

Application for Volunteer and/or Employment

Applicant Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Desired Position \_\_\_\_\_ Desired Status:  Paid Volunteer  Full Time  Part Time

Desired Salary: \$ \_\_\_\_\_ Date Available to Begin Work: \_\_\_\_\_

Have you ever worked for SCWEMS?  Yes  No If yes, when? \_\_\_\_\_

Have you ever been convicted of a felony?  Yes  No If yes, explain: \_\_\_\_\_

Are you authorized to work in the U.S.?  Yes  No

Have you ever had action taken or sanctions against your professional license(s)?  Yes  No

References

1. Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Company: \_\_\_\_\_
2. Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Company: \_\_\_\_\_
3. Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Company: \_\_\_\_\_

Licenses / Certifications

Drivers Lisc No.:	State:	Expiration:
CPR:	Org:	Expiration:
EMT License No.:	State:	Expiration:
Others:		

(Please attach copies of certifications to application when submitting)

Employment History

Employer Name:	Dates Employed:
Manager:	Contact:
May we contact this employer?	
Employer Name:	Dates Employed:
Manager:	Contact:
May we contact this employer?	
Employer Name:	Dates Employed:
Manager:	Contact:
May we contact this employer?	



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Other Info – (Days Available, Supporting Info)

I certify that the answers within this application are true and correct to the best of my knowledge. I authorize the South Central Wyoming Emergency Medical Services Joint Powers Board, or its designee, to investigate any statement made in this application. I understand that this application is not and is not intended to be a contract or any kind of agreement. In the event of being accepted as part of the named organization, I understand that any false or misleading information given on this application, correspondence, discussion, or interviews may result in immediate separation. I understand that I am required to abide all applicable rules, regulations, policies, protocols, guidelines of South Central Wyoming Emergency Medical Services Joint Powers Board.

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

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**Internal Use Only**

Service Area:
Application Accepted Date:
Recommended Action: