BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

FOR OFFICE USE ONLY

Date of Interview ____/____/____**Rate** _____

Orientation Date ____/____/____ **Empl. Number**_____

Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the Human Resources Department.

Position(s) applied for _____Date of application_____/_____/_____

Referral Source ☐ Advertisement ☐ Employee ☐ Relative ☐ Government Employment Agency
☐ Walk-in ☐ Private Employment Agency ☐ Other_____
Name of source (if applicable) _____

Name_____
LAST FIRST MIDDLE

Address_____Social Security # _____
STREET CITY STATE ZIP CODE

Telephone # (____)_____Mobile/Beeper/Other Phone # (____)_____E-mail Address_____

If necessary, best time to call you at home is ..... _____:_____ PM

May we contact you at work? ..... ☐ Yes ☐ No

If yes, work number and best time to call ..... (_____)_____ _____:_____ AM PM

If you are under 18 and it is required, can you furnish a work permit?..... ☐ Yes ☐ No

If no, please explain_____

Have you submitted an application here before? ..... ☐ Yes ☐ No

If yes, give position(s) and date(s)_____

Have you ever been employed here before?..... ☐ Yes ☐ No

If yes, give dates..... From ____/____/____ To ____/____/____

Are you legally eligible for employment in this country?..... ☐ Yes ☐ No

Date available for work.....____/____/____ What is your desired salary range?..... $_____

Type of employment desired ☐ Full-Time ☐ Part-Time

Type of work schedule interested in (check all that apply.) ☐ Days (1st Shift) ☐ Evenings ☐ Nights ☐ Weekends

Are you able to meet the attendance requirements of the position? ..... ☐ Yes ☐ No

Have you ever been bonded? ..... ☐ Yes ☐ No

Have you ever pled "guilty" or "no contest" to, or been convicted of a crime?..... ☐ Yes ☐ No

If yes, please provide date(s) and details_____

ANSWERING "YES" TO THESE QUESTIONS DOES NOT CONSTITUTE AN AUTOMATIC BAR TO EMPLOYMENT. FACTORS SUCH AS DATE OF OFFENSE, SERIOUSNESS AND NATURE OF THE VIOLATION, REHABILITATION AND POSITION APPLIED FOR WILL BE TAKEN INTO ACCOUNT.

Driver's license number required (essential job function) _____ State _____

BELL AMBULANCE, INC. IS AN EQUAL OPPORTUNITY EMPLOYER

Employment History

Provide the following information of your past and current employers, assignments or volunteer activities, starting with the most recent (use additional sheets if necessary). Explain any gaps in employment in comments section below.

EMPLOYER	TELEPHONE #	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS				
STARTING JOB TITLE/FINAL JOB TITLE		HOURLY RATE STARTING	PER	
IMMEDIATE SUPERVISOR AND TITLE		HOURLY RATE FINAL	PER	
REASON FOR LEAVING				

MAY WE CONTACT FOR REFERENCE? ☐ YES ☐ NO ☐ LATER

EMPLOYER	TELEPHONE #	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS				
STARTING JOB TITLE/FINAL JOB TITLE		HOURLY RATE STARTING	PER	
IMMEDIATE SUPERVISOR AND TITLE		HOURLY RATE FINAL	PER	
REASON FOR LEAVING				

MAY WE CONTACT FOR REFERENCE? ☐ YES ☐ NO ☐ LATER

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STARTING JOB TITLE/FINAL JOB TITLE		HOURLY RATE STARTING	PER	
IMMEDIATE SUPERVISOR AND TITLE		HOURLY RATE FINAL	PER	
REASON FOR LEAVING				

MAY WE CONTACT FOR REFERENCE? ☐ YES ☐ NO ☐ LATER

EMPLOYER	TELEPHONE #	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS				
STARTING JOB TITLE/FINAL JOB TITLE		HOURLY RATE STARTING	PER	
IMMEDIATE SUPERVISOR AND TITLE		HOURLY RATE FINAL	PER	
REASON FOR LEAVING				

MAY WE CONTACT FOR REFERENCE? ☐ YES ☐ NO ☐ LATER

References

List name and telephone number of two business/work references who are not related to you and are not previous supervisors. If not applicable, list two school or personal references who are not related to you.

NAME TELEPHONE NO. YRS. KNOWN

Educational Background (if job related)

A. List last three (3) Schools attended, starting with most recent. B. List number of years completed. C. Indicate degree, diploma or certification earned, if any. D. Grade Point Average or Class Rank. E. Major field of study. F. Minor field of study (if applicable).

A. SCHOOL	B. NUMBER OF YEARS COMPLETED	C. DEGREE/DIPLOMA	D. GPA CLASS RANK	E. MAJOR	F. MINOR

Skills and Qualifications

List any special training that you've completed that may qualify you as being able to perform job-related functions in the position for which you are applying.

Comment on any additional related experience(s) you may have had that may qualify you as being able to perform job-related functions in the position for which you are applying. (For Example: Clinical Experience, Home Health Care, Urgent Care, Senior Care, Pharmacy, Voluntary Service, etc.).

License and Certification Information

List all applicable licenses or certifications that you have and their expiration dates below:

LICENSE/CERTIFICATION # (IF APPLICABLE) DATE ISSUED EXP. DATE

LICENSE/CERTIFICATION # (IF APPLICABLE) DATE ISSUED EXP. DATE

LICENSE/CERTIFICATION # (IF APPLICABLE) DATE ISSUED EXP. DATE

LICENSE/CERTIFICATION # (IF APPLICABLE) DATE ISSUED EXP. DATE

Driving Record

List any violations within the past 8 years

Applicant Statement

I certify that all information I have provided in order to apply for and secure work with Bell Ambulance, Inc. is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) cancel further consideration of this application, or (ii) immediately discharge me from Bell Ambulance, Inc. whenever it is discovered.

I expressly authorize, without reservation, Bell Ambulance, Inc., its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees or representatives, for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that Bell Ambulance, Inc. does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from Bell Ambulance, Inc. and still wish to be considered for employment, it will be necessary to reapply and fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and Bell Ambulance, Inc. reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of Bell Ambulance, Inc. is authorized to make any assurances to the contrary and that no implied oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the President of Bell Ambulance, Inc.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT.

I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement.

Signature of Applicant _____ Date ____/____/____

Affirmative Action Voluntary Information

COMPLETION OF INFORMATION BELOW IS VOLUNTARY

We consider all applicants for positions without regard to race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve/national guard or any other similarly protected status. We also comply with all applicable laws governing employment practices and do not discriminate on the basis of any unlawful criteria.

To be completed by applicant on a voluntary basis. Not for interview purposes. To be filed separately from application.

In an effort to comply with requirements regarding government recordkeeping, reporting and other legal obligations which may apply, we invite you to complete this applicant data survey. Providing this information is STRICTLY VOLUNTARY. Failure to provide it will not subject you to any adverse personnel decision or action. Your cooperation is appreciated.

Please be advised that this survey is not a part of your official application for employment. It will not be used in any hiring decision. The information will be used and kept confidential in accordance with applicable laws and regulations.

PLEASE PRINT

Position(s) applied for _____ Date ____/____/____

Referral Source

- ☐ Walk-in
- ☐ Employee
- ☐ Advertisement
- ☐ Government Employment Agency
- ☐ Relative
- ☐ Private Employment Agency
- ☐ School
- ☐ Other _____

Name of person who referred you IF APPLICABLE _____

Applicant Information

Name _____ Telephone # _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

☐ Male ☐ Female

Please check one of the following Equal Employment Opportunity Identification Groups:

- ☐ White (not of Hispanic origin)
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Multiracial (having parents of different races)

THIS IDENTIFICATION GROUP IS RECOGNIZED ONLY IN THE STATE OF MICHIGAN

Applicant Information

Position(s) applied for ☐ Available ☐ Not Available

Other positions considered for _____

Hired ☐ Yes ☐ No

Position hired for _____ Date of hire ____/____/____

From the EEO job classifications listed below, which one best describes the position filled?

- ☐ Officials and Managers
- ☐ Professionals
- ☐ Technicians
- ☐ Sales Workers
- ☐ Office and Clerical Workers
- ☐ Craft Workers (skilled)
- ☐ Operations (semi-skilled)
- ☐ Laborers (unskilled)
- ☐ Service Workers

Notes _____

Completed by _____ Date ____/____/____

BACKGROUND INFORMATION DISCLOSURE INSTRUCTIONS

The Background Information Disclosure form (HFS64) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.

CAREGIVER BACKGROUND CHECK LAW
In accordance with the provisions of sections 48.685 and 50.065 of the Wisconsin Statutes, for persons who have been convicted of certain acts, crimes or offenses:

1. The Department of Health and Family Services (DHFS) may not license, certify or register the person or entity (Note: Employers and Care Providers are referred to as "entities");
2. A county agency may not certify a day care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed day care provider; and
5. An entity may not employ, contract with or permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at http://www.dhfs.state.wi.us/ at the Licensing link and then under the Caregiver Program link.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (REFERRED TO AS "ENTITIES")

Programs Regulated Under Chapter 48 of Wisconsin Statute	Treatment Foster Care, Family Day Care Centers, Group Day Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Day Care.
Programs Regulated Under Chapters 50, 51, and 146 of Wisconsin Statute	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Day Care Providers contracted through Local School Boards

THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client.
- Anyone who is a Day Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("nonclient resident").
- Anyone who is licensed by DHFS.
- Anyone who has a foster home licensed by DHFS.
- Anyone certified by DHFS.
- Anyone who is a Day Care Provider certified by a county department.
- Anyone registered by DHFS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT
Wisconsin's Fair Employment Law, ss. 111.31 - 111.395, Wisconsin Statutes, prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION: This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary, however your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health and Family Services' Caregiver Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
HFS-64 (Rev. 09/00)

BACKGROUND INFORMATION DISCLOSURE

Completion of this form is required under the provisions of sections 48.685 and 50.065 of the Wisconsin Statutes. Failure to comply may result in a denial or revocation of your license, certification or registration; or denial or termination of your employment or contract. Refer to the attached instructions (HFS-64 A) for additional information. Providing your social security number is voluntary, however, your social security number is one of the unique identifiers used to prevent incorrect matches.

Please print your answers.

Check the box that applies to you.

- ☐ Employee / Contractor (Including new applicant)
- ☐ Applicant for a license or certification or registration (including continuation or renewal)
- ☐ Household member / lives on premises - but not a client
- ☐ Other – specify:

NOTE: If you are an owner, operator, board member, or nonclient resident of a Bureau of Quality Assurance (BQA) regulated facility (1) print only your first, middle and last name; (2) complete Sections A and B; (3) sign the form; (4) complete the Appendix, HFS-69, in its entirety and (5) submit this form and the Appendix to the address noted in the Appendix Instructions.

Name - First and Middle	Name - Last	Position Title (Complete only if you are a prospective employe or contractor, or a current employe or contractor.) **Potential Employee**	
Any other names by which you have been known (including maiden name)	Birthdate	Gender (M / F)	Race
Address		Social Security Number(s)	

Business Name and Address of Employer or Care Provider (Entity)
Bell Ambulance, Inc., 549 E Wilson St, PO Box 070550, Milwaukee, WI 53207-0550

Section A - ACTS, CRIMES AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes,** list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ☐ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.	☐	☐
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐

(Continued on next page)

Section A - Continued	**YES**	**NO**
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ➢ If **Yes**, explain, including credential name, limitations or restrictions, and time period.	☐	☐

Section B – OTHER REQUIRED INFORMATION	**YES**	**NO**
1. Has any government or regulatory agency ever limited, denied or revoked your license, certification or registration to provide care, treatment or educational services? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➢ If **Yes,** explain, including when and where it happened and the reason.	☐	☐
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➢ If **Yes**, attach a copy of your discharge papers (DD214) if you were discharged within the past 3 years. ➢ You may be asked to provide a copy of your DD214 if your discharge occurred more than 3 years ago.	☐	☐
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes**, list each state and the dates you lived there.	☐	☐
5. Have you had a caregiver background check done within the last 4 years? ➢ If **Yes**, list the date of each check, and the name, address and phone number of the person, facility or government agency that conducted each check.	☐	☐
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health and Family Services, a county department, a private child placing agency, school board, or DHFS designated tribe? ➢ If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.	☐	☐

A "NO" answer to all questions does not guarantee employment, residency, a contract or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in HFS 12.05 (4), Wis. Adm. Code.

YOUR SIGNATURE	Date Signed

BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

RICK A. ZEHETNER
President

JAMES P. LOMBARDO
Executive Vice President

WAYNE A. JURECKI
Vice President, Chief Operating Officer

KEITH RADER, M.D.
Program Medical Director

MOTOR VEHICLE RECORD RELEASE AUTHORIZATION FORM

TO: Wisconsin Department of Transportation

The undersigned does hereby authorize the release and delivery of all motor vehicle driving records relating to the undersigned, including but not limited to personal information, to my employer.

Name of Employer: Bell Ambulance
PO Box 070550
Milwaukee, WI 53207

This authorization shall continue in effect until revoked by the undersigned in a subsequent writing delivered to you.

_____ _____
Signature Date

Full Name_____

Address_____

City, State, ZIP: _____

Driver's License Number_____

State_____