Remote Medical Service RMS Application for Employment

Personal Information

Please fill in all applicable fields - Failure to do so may delay your application.

Last Name:		Cell Phone Number:	
First Name:		Home Phone Number:	
Date of Birth (YYYY-MM-DD):		Address:	
		City:	
Social Insurance Number:		Province or State:	
Driver's License #:	Class	Country:	
Expiry Date (YYYY-MM-DD):		Postal or Zip Code:	

Medical/First-Aid Training

Check all that apply and attach photocopy of proof of certification for each.

☐ EMR ☐ EMT-A ☐ EMT-P	Registration #: Expiry Date (YYYY-MM-DD):		☐ Basic FA ☐ Standard FA ☐ Advanced FA	Certification #: Expiry Date (YYYY-MM-DD):	
☐ LPN ☐ RN ☐ Physician	Registration #: Expiry Date (YYYY-MM-DD):		☐ OFA-I ☐ OFA -III	Certification #: Expiry Date (YYYY-MM-DD):	

Other Training

Check all that apply and attach photocopy of proof of certification for each.

☐ H2S Safety	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ WHMIS	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ TDG	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ Bear Aware	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ NAPD Driver	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ Defensive Driving	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ Radio Operator	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ ATV Safety	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ Trailer Safety	Certification #:		Expiry Date (YYYY-MM-DD):	
☐ CSO/CSA/ CRSP	Certification #:		Expiry Date (YYYY-MM-DD):	

Employment History *Current or most recent first, etc.*

Name:
Phone Number:
Address:
Supervisor:

Name:
Phone Number:
Address:
Supervisor:

Name:
Phone Number:
Address:
Supervisor:

References *Do not include family or members of clergy.*

Name:
Phone Number:
Address:
Relationship:

Name:
Phone Number:
Address:
Relationship:

Name:
Phone Number:
Address:
Relationship:

Emergency Contact:

Name:
Phone Number:
Relationship:
Address:

By signing below, I hereby certify that the information I have provided is accurate and truthful, and I authorize Remote Medical Service to verify the information I have provided.

Signature

Signing Date (YYYY-MM-DD)

Office Use Only (The following payroll, tax, and health information is collected upon hire, and is strictly confidential):

Date of Hire (YYYY-MM-DD):

◯ Void Cheque ◯ Account Information (Include below):

Institution # Transit #: Account #:

◯ Single
◯ Married
◯ Other

Name of Spouse:

Number of Depedants:

☐ Allergies? Specify:

Reaction & Remedy:

☐ Epilepsy ☐ Heart Cond. ☐ Diabetes ☐ Asthma
☐ Back Problem
☐ Vision Loss
☐ Hearing Loss

Other:Cond.:

Medications:

Healthcare #: