HEALTHCARE

TRANSPORT LLC

Please email application to Hct.memphis@gmail.com

Please complete the following:

Complete Physical Form

Complete Drug Screen

Medical Testing Resources
4322 American Way
Memphis, TN 38118

901-795-5905
M - F '8am - 8pm
No appointment needed

Copies of:

Drivers License

SS Card

EMT / Paramedic License

CPR Card

Healthcare Transport, LLC
3002 Old Austin Peay
Memphis, TN 38128
Office: 901-877-8088 / Fax: 901-334-1895

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.t.*

Address: _____
Street *Address* Apartment/Unit #

_____
City *State* *ZIP* Code

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary$ _____

Position Applied for: _____

EMT/ Paramedic license number: _____ Expiration Date: _____

CPR Expiration Date: _____

Are you a citizen of the United States? YES ☐ NO ☐

If no, are you authorized to work in the U.S.? YES ☐ NO D

Have you ever worked for this company? YES ☐ NO ☐

If yes, when? _____

Have you ever been convicted of a felony? YES D NO D

If yes, explain: _____

Education

High School: _____ Address: _____

From: To: Did you graduate? YES ☐ NO ☐ Diploma:: _____

College: _____ Address: _____

From: To: Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: To: Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list *three professional references.*

Full Name: _____ Relationship:._____

Company: _____ Phone:._____

Address: _____

Full Name: _____ Relationship:._____

Company: _____ Phone:._____

Address: _____

Full Name: _____ Relationship:_____

Company: _____ Phone:_____

Address: _____

Previous Employment

Company: Phone:_____

Address: Supervisor:_____

Job Title: _____Starting Salary: $_____ Ending Salary:$_____

Responsibilities: _____

From: _____To:_____ Reason for Leaving:._____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

_____

_____

Company: _____ Phone:_____

Address: _____ Supervisor:_____

Job Title: _____Starting Salary: $_____ Ending Salary: $_____

Responsibilities: _____

From: _____To: _____ Reason for Leaving:_____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

_____

_____

Company: _____ Phone:_____

Address: _____ Supervisor:._____

Job Title: _____Starting Salary: $_____ Ending Salary: $_____

Responsibilities: _____

From: _____ To _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch: _____ From: _____ To: _____

Rank at discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer

By signing this application, I certify: That this application is complete and accurate to the best of my knowledge and that I have not made any attempt to conceal information and that false statements or omissions made on this application, during interviews, or on my resume, may be cause for dismissal. Further, Healthcare Transport, LLC or its agents may request employment information from my previous employers and persons or corporations who provide information related to my previous employment and will be released from any liability or damage. Also, I agree if required to undergo a medical examination by a company designated physician and understand that medical approval must be obtained before employment can be effected. I have noted that Healthcare Transport, LLC is an Equal Opportunity Employer and all applicants receive lawful consideration for employment without regard to Race, Religion, Color, Sex, Age, National origin, Disability, or Veteran Status. I realize that if I am hired, Healthcare Transport, LLC reserves the right to terminate my employment whenever the need arises.

_____ _____

Signature of Applicant Date

When submitting the completed application, please bring the following:

- Driver's License
- SS Card
- EMT / Paramedic License
- CPR Card
- Physical (If you have had a physical within the last 3 months, you may use that)
- Email address
- Direct Deposit Information (Bank Name, Bank Account number, Routing Number)

The Civil Rights Act of *1964 prohibits discrimination in employment because of* race, *color, gender, 19/igion, or national origin.* **The *Age*** *Discrimination Act* of *1967 prohibits discrimination on the basis of age with respect* to *individuals who* are *at least 40 years of* age *but less than 70 years of* age. *Title I employment provisions of* The *American with Disabilities Act of 1990 prohibits discrimination against qualified individuals with disabilities in job application procedures.*

HEALTHCARE TRANSPORT, LLC IS AN EQUAL OPPORTUNITY EMPLOYER. IT IS OUR POLICY THAT ALL APPLICANTS BE CONSIDERED SOLELY ON THE BASIS OF QUALIFICATIONS AND ABILITY. WITHOUT REGARD TO RACE, RELIGION, COLOR, SEX, AGE, NATIONAL ORIGIN, DISABILITY OR VETERAN STATUS

Authorization for Release of Information

To: Any Registrar, Dean, Principal or other authorized person at a school

Any Past or Present Employer, Any Law Enforcement agency or and Department or Agency of a City, County, State or Federal Government or any person having knowledge of my conduct or activities.

I,_____herby authorize Healthcare Transport, LLC or authorized representative bearing this release or copy thereof, within twelve months of its date, to conduct an appropriate check including but not limited to records, checks and personal interviews, for determination of my eligibility for employment.

I authorize all persons who may have information relevant to this check to disclose to Healthcare Transport, LLC or its agent, and I herby release all persons from liability on account of true and accurate disclosure. I herby further authorize that a photocopy of this authorization be considered as valid as an original.

The information obtained in the check if for the official use of Healthcare Transport, LLC, and or its clients and will not be released to other parties. Should there be any question as to the validity of authorization you may contact me as indicated below.

_____ _____

Signature *Date*

Read each* statement *carefully and affirm that you understand and* consent to *them by signing at the bottom of the page.

Employment is "at will". Employment at Healthcare Transport, LLC is for an indefinite and unspecified duration. If you are hired, you may leave employment at will, and the Company may discharge you, any, or all other employees at any time, without notice, and for any reason not prohibited by law.

_____ _____

Signature Date

CONSENT TO RELEASE MOTOR VEHICLE REPORT

NAME: _____

ADDRESS: _____

DRIVER'S LICENSE NUMBER: _____

STATE ISSUED: _____

DATE OF BIRTH: _____

SSNUMBER: _____

THE FAIR CREDIT REPORTS ACT REQUIRES YOUR CONSENT PRIOR TO RELEASING YOUR MOTOR VEHICLE RECORDS TO YOUR EMPLOYER AND/OR REPRESENTATIVE AGENCY.

BY SIGNING BELOW, I GIVE MY CONSENT TO PROVIDE COPIES OF MY MVR TO MY EMPLOYER, HEALTHCARE TRANSPORT, LLC AND TO OUT INSURANCE AGENCY, PETERSON INSURANCE SERVICES.

SIGNATURE:_____ DATE._____

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

MEDICAL STATEMENT
For Emergency Medical Services Professional License

The Office of Emergency Medical Services is the state agency responsible for the licensing of emergency medical services personnel. The mission of the agency is to oversee the delivery of pre-hospital emergency care and to safeguard the public from inappropriate or incompetent medical care in the pre-hospital environment. When issuing a license, it is understood that the individual can meet the demands, duties, and responsibilities listed below and examiner performing the evaluation is a licensed physician, nurse practitioner or physician assistant.

GENERAL DUTY REQUIREMENTS:
The general environmental conditions in which emergency medical service personnel work includes a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push, or lift and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having times to lift, move, carry and balance while moving in excess of 125 pounds (250 pounds 2 person lift). Motor Coordination is dexterity to bandage, splint and move patients, including properly applying invasive airways and administering injections.

Driving in a safe manner, accurately discerning street names, map reading, and the ability to correctly distinguish house numbers or business locations are essential tasks. Use of the telephone or radio for transmitting and responding to physician's advice is also essential. The ability to concisely and accurately describe orally to health professionals the patient's condition is critical. The provider must also be able to accurately summarize all data in the form of a written report.

_____
TYPE / PRINT APPLICANTS NAME

HAS BEEN EXAMINED AND DEMONSTRATES SUFFICIENT HEALTH TO PERFORM THE ESSENTIAL FUNCTIONS IN THE PRE-HOSPITAL ENVIRONMENT AS DESCRIBED IN THE GENERAL DUTY REQUIREMENTS ABOVE INCLUDING VISUAL ACUITY, SPEECH, HEARING, AND THE USE OF EXTREMITIES.

PRINT PROVIDER NAME	PROVIDER'S LICENSE NUMBER	STATE
PROVIDER'S SIGNATURE	DATE	

AUTHORIZATION FOR RELEASE OF INFORMATION:
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE EXAMINER NECESSARY FOR QUALIFICATION TO MY EMPLOYER FOR DETERMINATION OF MY ELIGIBILITY BY THE DIVISION OF EMERGENCY MEDICAL SERVICES.

SIGNATURE OF APPLICANT	SOCIAL SECURITY NUMBER	DATE

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."

HCT new company policy effective Immediately. May 14,2018

Due to some recent incidents in our patient care techniques HCT is adopting new patient transfer techniques to reduce our liability risk in this situation. It is now company policy that your patient is transferred to and from the stretcher by one of the following techniques.

Draw sheet

Extremity lift

Full body lift

two man lift

Hoyer lift.

By printing and signing your name below you are acknowledging you have read and completely understand the new policy stated above

Print name _____

Sign name_____Date_____

Thanks

John Sykes

901.569.2273

Form W-4 (2016)

Purpose. Complete Fonn W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Fonn W-4 each year and when your personal or financial situation changes.

Exemption from withholding. IfJou are exempt, complete only lines 1, 2, 3, 4, an 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: H another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for exemple, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all wor1<sheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not **be** a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child **tax** credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amoll"lt of nonwage income, such as interest or dividends, consider making estimated tax payments using Fonn 1040-ES, Estimated Tax for Individuals. Othefwise, **you** may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust **your** withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or mora than *one* job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Fonm W-4. Your withholding usually will be most accurate when all allowances are claimed on the Fonm W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this fonm.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Inlormation about any Mure developments affecting Form W-4 (such as legislation enacted after we release it) *wiH* be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent .	**A**
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B**
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if youaremarried andhave either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) .	**C**
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return .	**D**
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claima credit **(Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child .	**G**
H	Add lines A through G and enter total here. **(Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- ---------- ---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Fonm **W•4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is **subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

0MB No. 1545-0074

©16

1	Your first name and middle initial / Last name	12 **Your social security number**
	Home address (number and street **or** rural route)	30 Single 0 Married O Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, ctieci< the "Single" box.
	City or town, state, and ZIP code	**4 If your last name differs from that 5hown on your social security card, check here. You must call 1-800-n2-1213 for a replacement card.** ▶ D
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liabilitv. If you meet both conditions, write "Exempt" here . ▶ 111	

Under penalties of perJury, I declare that I have examined this cert1f1cate and, to the best of my knowledge and belief, 1t 1s true, correct, and complete

Employee's signature
(This form Is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)