NAME:	SS#
ADDRESS:	CITY:
STATE: | ZIP:	PHONE:
E-MAIL:	CELL:
AGE: **DOB:**	

EMPLOYMENT HISTORY:	POSITION	
FROM: TO:		
FROM: TO:		

EDUCATION HISTORY	
COLLEGE:	
TRADE,BUSINESS OR CORRESPONDENCE:	
Number Years Licensed EMT :	

LIST ALL EDUCATIONAL COURSE YOU HAVE TAKEN, THAT YOU BELIEVE WILL ENHANCE YOUR ABILITY TO DO THE JOB.	
CIRCLE AVAILABLE DAYS: M. T. W. TH. F. SA. SU	CIRCLE AVAILABLE NIGHT: M. T. W. TH. FR. SA. SU.

REFERENCES: NAME	PHONE NO.	BUSINESS	YEARS KNOWN

AUTHORIZATION

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information. I understand that my employment with Extreme Sports Medics would be "at will" and can be terminated by either the company or me at any time, for any reason.

Date_____Signature_____

Shirt Size : T-Shirt_____ Dress Shirt_____

Paul Lay 405-205-1011
Toll Free 877-376-3687
Fax: 405-399-4949