



Application for Employment

AN EQUAL OPPORTUNITY EMPLOYER

EMS Medical Billing Associates, LLC
9401 W. Brown Deer Road Ste. 101 | Milwaukee, WI 53224
(414) 365-9900

EMS Medical Billing Associates, LLC is an equal opportunity employer. Applicants that require accommodation to complete the application, testing, or interviewing process should contact our Human Resources Department.

Position Applying for _____ Today's Date _____

Name _____ Social Security No. _____
Last First Middle

Address _____
Street City State ZIP Code

Telephone No. _____ Other Phone No. _____ Date of Birth _____

E-mail Address _____ Date Available for Employment _____

Driver's License No. _____ State _____ Expiration Date _____

Type of employment desired: Full-time Part-time Internship/Co-op Seasonal Temporary

Referral Source: Advertisement Walk-In School Employee _____
 Private Employment Agency Company Web Site Other _____

Are you legally eligible for employment in the United States of America? Yes No

If you are under the age of 18 and the position you are applying for requires a work permit, can you furnish a work permit? Yes No

What is your desired hourly rate of pay or salary range? \$ _____ per hour or \$ _____ salary

Will you commute if the job you are applying for requires it? Yes No

Will you work overtime if required? Yes No

If you replied "no," please explain: _____

When is the best time to call you? _____ May we contact you at work? Yes No

If you replied "yes," please list your work number and best time to call: _____

Have you submitted an application here before? Yes No

If you replied "yes," please provide a date and the position applied for: _____

Have you been employed by EMS Medical Billing Associates, in the past? Yes No

Is this application a request for reemployment following an extended military leave of absence from this company? Yes No

Have you ever been bonded? Yes No

Answering "yes" to the following question does not automatically disqualify you for employment. Each case will be individually considered based on specific factors.

Have you ever pleaded "guilty" or "no contest" to or ever been convicted of a crime? Yes No

If you replied "yes," please provide a date and a brief explanation: _____

You only need to answer the following question if you are applying for a position that demands driving as part of the position.

Have you possessed a valid driver's license from a state other than Wisconsin in the last 10 years? Yes No

If you replied "yes," please provide a Driver's License Number and the State in which you possessed a valid driver's license:

Driver's License No.: _____ State: _____

Employment History

Starting with the most recent, please provide the following information of your past and current employers, assignments, or volunteer activities. Explain any gaps in the Employment-related Comments section.

Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		
Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		
Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		
Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		

Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		

Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		

Employer	Duration of Employment Began _____ Ended _____	Job Responsibilities
Address	Phone Number	
Starting Job Title & Final Job Title	Starting Hourly Rate or Salary	
Immediate Supervisor's Name & Title	Ending Hourly Rate or Salary	
Reason for Leaving		
May we contact this employer for reference? Yes No Later		

Employment-related Comments Feel free to elaborate upon any employment-related issues or gaps (exclude any comments that would reveal race, color, religion, sex, national citizenship, age, mental or physical disabilities, veteran/reserve, national guard, or any other similarly protected status).

Driving Record If applicable for the position you are applying for, list all motor vehicle violations and accidents you have incurred with in the last five years.

Educational Background

Starting with the most recent, please provide at least three schools you have attended, as well as the number of years attended, degree or diploma acquired, GPA, major, and/or minor at each school.

School Attended	Years Attended	Degree or Diploma	GPA	Major	Minor

References

List the name, phone number, and number of years known of three business-related references who are not related to you and are not previous supervisors. If not applicable, list three personal references who are not related to you.

Name	Phone Number	Number of Years Acquainted

Associations

List professional trade, business, civic associations, or any offices held (exclude memberships that would reveal race, color, religion, sex, national citizenship, age, mental or physical disabilities, veteran/reserve, national guard, or any other similarly protected status).

Name of Association	Level of Association

Accomplishments

List special accomplishments, publications, awards, etc. (exclude memberships that would reveal race, color, religion, sex, national citizenship, age, mental or physical disabilities, veteran/reserve, national guard, or any other similarly protected status).

Career Goals

Please provide your career goals as an employee at EMS Medical Billing Associates, LLC.

Skills & Qualifications

Summarize any special training, skills, licenses, or certifications that may qualify you as being able to perform job-related functions in the position for which you are applying. Also, list any computer or word-processing skills and training.



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Acknowledgement

Please read carefully, initial each paragraph, and sign below.

____ I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any misrepresentation, falsification, or omission of information on this application or any document used to secure employment shall be grounds for rejection of this application or immediate discharge if I am employed, regardless of the time elapsed before discovery.

____ I hereby authorize the Company to thoroughly investigate the information on my application, my references, work record, education and other matters related to my suitability for employment and, furthermore, authorize the references I have listed to disclose to the Company all letters, reports, and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the Company, my former employers and all other persons or entities from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosures.

____ The Company adheres to a policy of at-will employment which means that each employee and the Company each retain the right to terminate the employment relationship and that the Company retains the right to modify an employee's position or compensation at any time, with or without cause or notice. No one other than the President has the authority to make any binding promise or enter into any agreement inconsistent with Company's at-will policy and any such agreement must be in writing and signed by both the employee and the President of the Company to be effective.

____ I understand that this application remains current for only 30 days. After 30 days, if I have not heard from the employer, and still wish be considered for employment, I must complete and submit a new application.

____ I understand that EMS Medical Billing Associates, LLC is committed to a policy of Equal Employment Opportunity. EMS Medical Billing Associates, LLC will not discriminate on the basis of age, gender, race, color, religion, national origin, disability, marital status, or any other legally protected characteristic under federal, state or local law. In accordance with applicable law, EMS Medical Billing Associates, LLC will make reasonable accommodation for qualified persons with disabilities. Applicants for employment who have a disability are encouraged to contact the Human Resources Department to request assistance and/or a reasonable accommodation.

____ I also understand that if I am hired, I will be required to provide proof of identification and legal authorization to work in the United States of America.

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

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

Signature of Applicant _____ Date _____

FOR OFFICE USE ONLY	
Application Received By _____	Date _____



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Affidavit Authorizing Release of Information

I _____, being an applicant for employment at
First Name Middle Name Last Name
 EMS Medical Billing Associates, LLC, authorize an agent of EMS Medical Billing Associates, LLC to obtain information and/or records pertaining to me.

These sources include, but are not limited to:

- any present or previous employer with the exception of those indicated on my application;
- any educational institution that I have attended;
- any medical institution where I have been treated;
- any law enforcement agency.

I release any individual or institution, including its officers, employees, or related personnel—both individually and collectively—from any and all liability for damages of whatever kind (including actions brought under 895.50 Wisconsin Statutes).

I agree that a photocopy or fax of this affidavit will have the same force and effect as the original.

I have read the above and know it to be true and correct as to be the best of my knowledge.

(This portion must be completed in front of a notary at time of interview.)

Dated at _____, this _____ day of _____ 20____.
Location State

 Applicant's Signature
(to be signed in front of a notary)

Subscribed and sworn to before me this _____ day of _____ 20____.

 Notary Public

My commission expires _____.



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Motor Vehicle Record Access Authorization

You only need to answer this page if you are applying for a position that demands driving as part of the position.

Applicant or Employee:

I understand that driving may be part of the job description and I voluntarily authorize the current liability carrier of EMS Medical Billing Associates, LLC to access my motor vehicle record(s) and provide a copy to EMS Medical Billing Associates, LLC This authorization shall be valid for this and any future motor vehicle record inspections that may be requested by EMS Medical Billing Associates, LLC I understand and agree that EMS Medical Billing Associates, LLC may consider my motor vehicle record when determining whether to extend an offer of employment to me and in making other employment decisions in the event that I am hired by the EMS Medical Billing Associates, LLC

Name _____
Last First Middle

Driver's license No. _____ State _____ Expiration Date _____

Date of Birth _____

Company EMS Medical Billing Associates, LLC

Signature of Applicant _____ Date _____

Voluntary Self-Identification Form

EMS Medical Billing Associates, LLC is an Equal Opportunity/Equal Access/Affirmative Action employer and complies with all federal and state regulations. Employees are treated during employment and qualified applicants are considered for employment without regard to race, religion, color, sex, age, national origin or ancestry, marital status, parental status, sexual orientation, disability, or status as a veteran.

EMS Medical Billing Associates, LLC is subject to certain governmental recordkeeping and reporting requirements for administration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify your race and ethnicity. Submission of this information is voluntary and refusal to provide such information will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Name: _____ Employee ID Number: _____
Last Name First Name Middle Initial to be completed by Human Resources

Acknowledgement (select one)

I understand the reason for this request for voluntary self-identification as stated above and choose to decline submission of this information.

I understand the reason for this request for voluntary self-identification as stated above and choose to complete this form.

Gender Male Female

Ethnicity (select one)

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Not Hispanic or Latino

Race (select all that apply)

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, or Vietnam.

Black or African American—A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island.

White (not Hispanic or Latino)—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Two or More Races (Not Hispanic or Latino) – All persons who identify with more than one of the above five races.

The information I have provided to EMS Medical Billing Associates, LLC is true and complete to the best of my knowledge.

Employee or Applicant Signature: _____ Date: _____

BACKGROUND INFORMATION DISCLOSURE (BID)

INSTRUCTIONS

The Background Information Disclosure form (F-82064) 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 Chapters 48.685 and 50.065, Wis. Stats., for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) 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 child 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 child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at <http://DHS.wisconsin.gov/caregiver/StatutesINDEX.HTM>.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child 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 Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	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	Child 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 Child 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 DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Chapters 111.31 - 111.395, Wis. Stats., 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 Services' Caregiver Misconduct 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.

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. 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 instructions (F-82064A) on page 1 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) Household member / lives on premises - but not a client
- Applicant for a license or certification or registration (including continuation or renewal) Other – Specify:

NOTE: If you are an owner, operator, board member, or non client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)		
Any Other Names By Which You Have Been Known (Including Maiden Name)		Birth Date	Gender (M / F)	Race
Address			Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)				

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any 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.	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10 th 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.	<input type="checkbox"/>	<input type="checkbox"/>
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: <input type="checkbox"/> (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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>

(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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➤ If yes, indicate the year of discharge: _____ ➤ Attach a copy of your DD214 if you were discharged within the last 3 years.	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you resided outside of Wisconsin in the last 3 years? ➤ If Yes , list each state and the dates you lived there.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS designated tribe? ➤ If Yes , list the review date and the review result. You may be asked to provide a copy of the review decision.	<input type="checkbox"/>	<input type="checkbox"/>

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 DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed
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