



MOSAIC MEDICAL SERVICES INC.

403.726.1239

info@mosaicmedicalservices.com

EMPLOYMENT APPLICATION FORM

PERSONAL INFORMATION

FIRST NAME: _____

LAST NAME: _____

MIDDLE INITIAL: _____

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

E-MAIL ADDRESS: _____

ARE YOU 18 OR OLDER? **YES/NO**

ARE YOU LEGALLY ELIGIBLE TO WORK IN CANADA? **YES/NO**

ARE YOU BONDABLE? **YES/NO**

DO YOU HAVE A VALID DRIVERS LICENCE? **YES/NO**

DO YOU HAVE A CLASS 4 DRIVERS LICENCE? **YES/NO**

DO YOU HAVE A VEHICLE? **YES/NO**

DO YOU HAVE CURRENT ACP REGISTRATION? **YES/NO**

WHAT IS YOUR RO#? _____

ARE YOU TRAINED IN 12-1 SKILLS? **YES/NO**

EDUCATION

TYPE	NAME & ADDRESS OF SCHOOL	PROGRAM	WHEN DID YOU ATTEND	DID YOU GRADUATE
HIGH SCHOOL				
COLLEGE OR UNIVERSITY				
BUSINESS OR TRADE SCHOOL				
OTHER				

WHAT TICKETS DO YOU HAVE?

TICKET	YES	NO
CPR LEVEL C		
BTLS/ACLS		
H2S		
WHMIS		
HAZMAT		

ARE YOU A CERTIFIED CPR OR 1ST AID INSTRUCTOR? **YES/NO**

DO YOU HAVE ANY OTHER TRAINING? **YES/NO**
IF YES, PLEASE EXPLAIN.

EXPERIENCE

MAY WE CONTACT YOUR PRESENT AND PAST EMPLOYERS? **YES/NO**

PLEASE LIST YOUR 3 MOST RECENT JOBS.

COMPANY NAME, ADDRESS, PHONE NUMBER			
FIRST DAY OF EMPLOYMENT			
LAST DAY OF EMPLOYMENT			
RATE OF PAY			
JOB TITLE			
JOB DUTIES			
SUPERVISOR'S NAME			
REASON FOR LEAVING			

PLEASE LIST AND DESCRIBE ANY VOLUNTEER WORK THAT YOU HAVE DONE.

DO YOU HAVE ANY DISABILITIES OR INJURIES THAT WILL AFFECT YOUR ABILITY TO PERFORM ANY OF THE DUTIES REQUIRED OF YOU FOR THIS JOB? **YES/NO**

IF YES, PLEASE EXPLAIN.

HAVE YOU EVER RECEIVED WORKERS COMPENSATION? **YES/NO**

IF YES, PLEASE EXPLAIN.

ARE YOU COMFORTABLE WORKING IN A REMOTE AREA FOR A PROLONGED PERIOD OF TIME (NO MORE THAN 3 WEEKS)? **YES/NO**

WHAT IS YOUR AVAILABILITY?

WHEN ARE YOU AVAILABLE TO START? _____

*****BY SIGNING THE APPLICATION, YOU AGREE THAT ALL INFORMATION DISCLOSED IS TRUE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE. ANY FALSE INFORMATION WILL STOP YOUR APPLICATION FROM BEING PROCESSED AND MAY RESULT IN TERMINATION*****

SIGNATURE _____ **DATE OF APPLICATION** _____

PLEASE SUBMIT TO MOSAIC MEDICAL SERVICES VIA FAX 403-726-1230 OR E-MAIL Charlie@mosaicmedicalservices.com

*****THE INFORMATION COLLECTED HERE IS STRICTLY CONFIDENTIAL AND WILL ONLY BE USED BY OUR OFFICE FOR EMPLOYMENT PURPOSES*****

WE WOULD LIKE TO TAKE THE TIME TO THANK YOU FOR YOUR APPLICATION. IT WILL BE KEPT ON FILE FOR UP TO 6 MONTHS. ONLY PROSPECTFUL CANDIDATES WILL BE CONTACTED.