

MEDICAL EMPLOYMENT APPLICATION

We consider applications for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, sexual orientation, citizenship status, genetic information or any other legally protected status.

(PLEASE PRINT)

Last Name		First Name		Middle Name
Present Address	Street	City	State	Zip Code
Permanent Address	Street	City	State	Zip Code
Telephone Number(s)		E-mail	Social Security Number (Voluntary)	
Valid Driver's License Number (if applicable)		State	Expiration Date	

Date of Application _____ Date Available to Start _____

Position Applied For _____ Number of Hours Per Week _____

Employment Status Desired? (please check all that apply)

Status: Full Time Part Time Temporary Per Diem

Shift: Day Evening Night Weekend Rotating Shift

Are you eligible for employment within the United States? Yes No

Proof of citizenship or immigration status will be required upon employment.

Are you now or have you ever been sanctioned by or excluded from the Medicare and/or Medicaid system? Yes No

Have you ever been bonded? Yes No

If Yes, on what jobs? _____

Have you ever been employed by us before? Yes No

If Yes, give dates _____

Do any of your friends or relatives work here? Yes No

If Yes, give name and relationship _____

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

EDUCATION AND PROFESSIONAL TRAINING

	Name and Address of School or University	Major Course of Study	Number of Years Completed	Degree/Diploma
High School				
Trade School				
Undergraduate College				
Graduate Study				
Other (specify)				

CERTIFICATIONS, REGISTRATIONS AND LICENSES

Certification, Registration or License Type	Document Number	State	Date Issued	Expiration Date	Temporary or Permanent	HR Staff Verified
					T <input type="checkbox"/> P <input type="checkbox"/>	
					T <input type="checkbox"/> P <input type="checkbox"/>	
					T <input type="checkbox"/> P <input type="checkbox"/>	

Has your License/Registration/Certification ever been under review, revoked or suspended because of activity related to patient care or the performance of your duties in your profession? Yes No

If Yes, explain: _____

ADDITIONAL INFORMATION

SPECIALIZED SKILLS

- Data entry Typing (speed: _____)
- Switchboard Shorthand (speed: _____)
- Medical terminology Dictaphone

Computer software: _____

Medical information systems: _____

OTHER QUALIFICATIONS

Summarize special job-related skills and qualifications or additional information you feel may be helpful to us in considering your application.

Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Can you perform the essential functions of the job, for which you are applying, either with or without reasonable accommodation?

_____ YES _____ NO

REFERENCES

1.	()		
	Name		Phone #
	Address	Association	Years Known
2.	()		
	Name		Phone #
	Address	Association	Years Known
3.	()		
	Name		Phone #
	Address	Association	Years Known

FOR PERSONNEL DEPARTMENT USE ONLY

Position(s) applied for: _____

Is position(s) open? Yes No

Position(s) considered for: _____

Interview arranged: Yes No Date: _____ Time: _____

Interviewer: _____

Remarks: _____

Date of hire: _____ Start date: _____

Job title: _____

Hired by: _____

Name and Title

Date

Salary: _____ Department: _____

NAME: _____ POSITION: _____ DATE: _____ / _____ / _____

EMPLOYMENT EXPERIENCE

Start with your present or most recent job. Include any job-related military service assignments. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

1.	Employer	Dates Employed	From	To
	Address	Work Performed		
	Telephone Number(s)			
	Job Title	Supervisor		
	Reason for Leaving			
2.	Employer	Dates Employed	From	To
	Address	Work Performed		
	Telephone Number(s)			
	Job Title	Supervisor		
	Reason for Leaving			
3.	Employer	Dates Employed	From	To
	Address	Work Performed		
	Telephone Number(s)			
	Job Title	Supervisor		
	Reason for Leaving			
4.	Employer	Dates Employed	From	To
	Address	Work Performed		
	Telephone Number(s)			
	Job Title	Supervisor		
	Reason for Leaving			

If you need additional space, please continue on a separate sheet of paper.

List professional, trade, business or civic activities and offices held.

You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:

APPLICANT'S STATEMENT

How did you learn about our facility?

Advertisement: _____
(please list publication)

Web Posting: _____
(please list site)

Inquiry: _____
Date Time

Friend/Relative: _____

Other: _____

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Signature of Applicant

Date

This Application For Employment is sold for general use throughout the United States. Amsterdam Printing assumes no responsibility for the use of said form or any questions which, when asked by the employer of the job applicant, may violate State and/or Federal Law.

