EMPLOYMENT APPLICATION

NAME:_____DATE:_____
FIRST M.I. LAST

PRESENT ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE NUMBER: ( ) _____ SOC. SEC. #: _____

APPLYING FOR POSITION OF:_____ AVAILABLILITY_____

SALARY EXPECTED: _____ DO YOU HAVE TRANSPORTATION TO WORK _____

ARE YOU WILLING AND AVAILABLE TO WORK OVERTIME IF NECESSARY ? _____

DO YOU HAVE ANY DISABILITY OR HEALTH PROBLEM THAT MIGHT PREVENT YOU FROM PERFORMING YOUR JOB IN A SAFE AND EFFICIENT MANNER ? _____

HAVE YOU EVER BEEN BONDED ? _____ EVER DENIED BOND ? _____

ARE YOU A CITIZEN OF THE UNITED STATES: _____

IF NOT, DO YOU HAVE REQUIRED DOCUMENTS TO WORK IN THIS COUNTRY ? _____

HAVE YOU EVER SERVED IN THE MILITARY ? _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME ? (EXCLUDING TRAFFIC VIOLATIONS) _____ IF YES, EXPLAIN: _____
(A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU)

DRIVERS LICENSE: STATE: _____ NUMBER: _____ EXP: _____

HAVE YOU TAKEN ANY ILLEGAL DRUGS WITHIN THE LAST 30 DAYS ? _____

HAVE YOU EVER BEEN DISCHARGED OR FORCED TO RESIGN ? (IF YES, PLEASE EXPLAIN)
_____

DID YOU RECEIVE ANY DISCIPLINARY ACTION WITHIN THE LAST 12 MONTHS OF ACTIVE EMPLOYMENT ? (IF YES, PLEASE EXPLAIN) _____

REFERENCES: NAME TWO PEOPLE WHO HAVE KNOWN YOU AT LEAST TWO YEARS (DO NOT INCLUDE RELATIVES, FORMER EMPLOYERS, OR PERSONNEL OF THIS COMPANY).

NAME ADDRESS BUSINESS PHONE

_____

_____

_____

LIST NAME OF THE BANK YOU DO BUSINESS WITH: _____

SCHOOLS	NAME & LOCATION	# OF YEARS	DEGREE	QPA
GRADE SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, NIGHT OR CORRESPONDENCE				
APPRENTICESHIP				

MARK THE APPROPRIATE EXPERIENCE:

DOCTORS ASSISTANT _____	SECRETARIAL _____	ACCOUNTING _____
TYPING WPM _____	ACCT. PAYABLE _____	ACCT. RECV. _____
X-RAY TECH _____	MED. TRANSCRIPTION _____	PHYS. THERAPY _____
PHYS. THERAPY _____	SHORTHAND WRITING _____	COMPOSING LETTERS _____
PAYROLL _____	QUARTERLY REPORTS _____	INSURANCE FORMS _____
COLLECTIONS _____	COMPUTER _____	OFFICE MACHINES _____
RECEPTIONIST _____	PHONE SYSTEMS _____	

PLEASE READ CAREFULLY AND SIGN BELOW:

I CERTIFY THAT THE FACTS SET FORTH IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE SUFFICIENT CAUSE FOR DISQUALIFICATION FROM CONSIDERATION FOR HIRE OR FOR DISMISSAL. I AUTHORIZE THE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION AND AUTHORIZE THE RELEASE OF ANY INFORMATION AND/OR DOCUMENTS CONCERNING MYSELF BY ANY FORMER EMPLOYER, PERSON, FIRM, CORPORATION, CREDIT AGENCY, OR GOVERNMENT AGENCY, IN CONSIDERATION OF THE REVIEW OF THIS APPLICATION. I RELEASE THE REVIEWER, THE DOCTOR, THE CLINIC, AND ALL PROVIDERS OF INFORMATION CONCERNING ME FROM ANY LIABILITY AS A RESULT OF FURNISHING AND RECEIVING THIS INFORMATION.

I AGREE THAT IF I AM EMPLOYED, I WILL CONFORM MY CONDUCT TO THE DOCTOR'S RULES AND REGULATIONS. I ALSO UNDERSTAND AND AGREE THAT IF I AM EMPLOYED, MY EMPLOYMENT WILL BE "AT WILL" FOR NO DEFINITE PERIOD OF TIME, AND CAN BE TERMINATED AT ANY TIME WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE. I UNDERSTAND THAT NO ONE OTHER THAN THE DOCTOR HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED TIME. I ALSO UNDERSTAND THAT ANY EMPLOYMENT MANUALS OR HANDBOOKS THAT MAY BE DISTRIBUTED TO ME DURING THE COURSE OF MY EMPLOYMENT SHALL NOT BE CONSTRUED AS A CONTRACT.

DATE: _____ SIGNATURE:_____