

EMPLOYMENT APPLICATION

DATE: _____

NAME: _____
 LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

PHONE NUMBER: _____ CELL PHONE NUMBER: _____

POSITION SOUGHT: _____

WILL YOU WORK? FULL TIME ___ PART TIME ___ PRN ___

TEMPORARY ___

Do you have the legal right to work in the United States? Yes ___ No ___

If no, please explain _____

Have you pleaded guilty to or been convicted of a misdemeanor or felony charge, including any suspected execution or imposition of sentence, or any period of probation or parole? Yes ___ No ___

Note: Answering "yes" does not automatically disqualify you from employment. Factors such as nature of the offense, date and type of job for which you are applying will be considered. If yes, please explain _____

Are you listed on the Department of Social Services (DSS), Division of Aging Employee Disqualification List of those found to have abused or neglected elderly or handicapped patients or residents? Yes ___ No ___

Are you under 18 years of age? Yes ___ No ___

Have you ever been employed by Nevada Medical Clinic? Yes ___ No ___
If yes, what dates? _____ What Department? _____

If you worked here under another name, please list name: _____

Do you have any relatives employed at Nevada Medical Clinic? Yes ___ No ___

If yes, state name(s) and Department(s) _____

What is the highest level of education completed? _____

Have you passed the G.E.D. exam? Yes ___ No ___

Schooling Level	Name, City & State	Courses Studied	Diploma/Degree Received
High School			
College of University			
Professional, Vocational, Technical College			
Other			

Please check the following that you have used before:

Typing ___ Speed ___ Medical Terminology ___ Dictaphone ___ 10-Key ___

Misys Software ___ Word ___ Excel ___ Power Point ___

PROFESSIONAL LICENSE AND/OR CERTIFICATIONS

Are you currently: Registered __ Licensed __ Certified __ Permanent __ Eligible for: Registration __ Licensure __ Certification __ Temporary __			
If Licensed	Type: License # :	State Issued: License Expires:	Date:
<hr/>			
Registered	Type: License #:	State Issued: License Expires:	Date:
<hr/>			
Or Certified	Type: License #:	State Issued: License Expires:	Date:

WORK HISTORY
PLEASE LIST YOUR CURRENT EMPLOYMENT FIRST.

Firm Name:	Dates Employed: From _____ to _____	Job Title:
Street Address:	Final Salary \$ _____	Job Duties:
City & State	___ Hour ___ part time ___ Week ___ full time ___ Month ___ Year	Reason for leaving:
Phone: Supervisor:	Employer Comments:	
Firm Name:	Dates Employed: From _____ to _____	Job Title:
Street Address:	Final Salary \$ _____	Job Duties:
City & State	___ Hour ___ part time ___ Week ___ full time ___ Month ___ Year	Reason for leaving:
Phone: Supervisor:	Employer Comments:	
Firm Name:	Dates Employed: From _____ to _____	Job Title:
Street Address:	Final Salary \$ _____	Job Duties:
City & State	___ Hour ___ part time ___ Week ___ full time ___ Month ___ Year	Reason for leaving:
Phone: Supervisor:	Employer Comments:	
Firm Name:	Dates Employed: From _____ to _____	Job Title:
Street Address:	Final Salary \$ _____	Job Duties:
City & State	___ Hour ___ part time ___ Week ___ full time ___ Month ___ Year	Reason for leaving:
Phone: Supervisor:	Employer Comments:	

REFERENCES

Give name(s) of persons we may contact to verify your qualifications for the position. Please do not list relatives and please do not duplicate reference information listed in your employment history. PLEASE COMPLETE.

NAME: _____ OCCUPATION _____

PHONE NUMBER _____ ADDRESS _____

NAME: _____ OCCUPATION _____

PHONE NUMBER _____ ADDRESS _____

NAME: _____ OCCUPATION _____

PHONE NUMBER _____ ADDRESS _____

I AGREE:

The information contained in this application for employment is correct and complete. I am not on the Employee Disqualification List of any state, including Department of Social Services (DSS), Division of Aging as established under Missouri Law section 660.315 RSMo. Employment of individuals on any state's Disqualification List is prohibited if applicable to Nevada Medical Clinic's business.

I UNDERSTAND:

False statements, answers, or omissions on this application shall disqualify me from consideration for employment or will result in my dismissal after employment. My employment is based upon the receipt of satisfactory references and my ability to perform the basic qualifications of the position for which I have applied.

All job offers are conditional.

My application is valid for a period of one (1) year and I must physically re-apply for employment after that.

My employment with Nevada Medical Clinic would be entered into voluntarily. Either I or Nevada Medical Clinic can end the employment relationship at any time.

Failure on my part to disclose a conviction for other than minor traffic offense (unless minor traffic offense are job related) will be grounds for dismissal or non-hire.

I CONSENT:

For Nevada Medical Clinic to investigate any or all information concerning my previous employment, education and licenser.

To release any employers, references, educational institutions and licensure from all liability for any damages in furnishing said information.

Date _____

Signature _____

Signature is required in order for your application to be considered for employment.

Human Resources Use Only

If this person is a former employee, are they eligible for re-hire? Yes ___ No ___

**Authorization to Release Employee Information Regarding Current and/or
Previous Employment.**

I, _____, authorize Nevada Medical Clinic to contact my present/previous employer for release of my employment information for hiring purposes only. Nevada Medical Clinic will not disclose this information to anyone else unless authorized by the impending employee.

DISCLOSURE REGARDING PROCUREMENT OF CONSUMER REPORT

In connection with your application for employment, please be advised that we are required by Missouri law to conduct a criminal background check. This will be accomplished by requesting information through a consumer reporting agency with respect to information inside or outside the State of Missouri.

I acknowledge receipt of this disclosure and authorize that a criminal background check pursuant to Missouri law be conducted.

Applicant Signature: _____

Date: _____

A Word About Our Drug Screening Policy.....

It is the policy of Nevada Medical Clinic to promote a drug and alcohol free workplace in order to provide the highest quality of service and a safe environment for patients, employees and visitors. This includes the use of legal prescriptions which may impair employee job performance.

Passing a post-offer drug screen test may be required for employment at Nevada Medical Clinic.

If you take prescription medication, please bring proof of a valid prescription (either a doctor's note or the bottle) to your drug screening appointment, if required.

Your cooperation helps us provide the best information for your test and allows faster processing.

I understand that I may be required to participate in a post-offer drug screen test.

Applicant Signature: _____

Date: _____