

Employment Application

(PRINT IN INK OR TYPE)

DATE: _____

Docs Medical Group, Inc. is an Equal Employment Opportunity employer. Prospective employees will receive consideration without discrimination because of race, creed, color, sex, age, national origin, handicap/ disability or veteran status.

LAST NAME		FIRST			MIDDLE		
TELEPHONE NUMBER ()				ALTERNATE TELEPHONE (IF APPLICABLE) ()			
PRESENT ADDRESS	NO.	STREET	CITY	STATE	ZIP	COUNTRY	
MAILING ADDRESS	NO.	STREET	CITY	STATE	ZIP	COUNTRY	
E-MAIL ADDRESS							
@							

Please answer all questions. If a question is not applicable print N/A in entry. All information provided on this application is confidential.

POSITION APPLIED FOR (IN ORDER OF YOUR PREFERENCE) FIRST: _____ SECOND: _____ THIRD: _____ _____		TYPE: OF EMPLOYMENT DESIRED: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> OTHER									
WILLING TO RELOCATE? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN: _____		WILL YOU WORK ROTATING SHIFTS INCLUDING NIGHTS, WEEKENDS? <input type="checkbox"/> YES <input type="checkbox"/> NO									
ARE YOU LEGALLY ELIGIBLE TO WORK IN THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO		MINIMUM SALARY REQUIRED EARLIEST AVAILABLE DATE \$ _____ PER _____									
LIST ALL RELATIVES EMPLOYED WITH OUR COMPANY: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">NAME</th> <th style="width: 20%;">RELATIONSHIP</th> <th style="width: 30%;">DEPARTMENT</th> <th style="width: 20%;">POSITION</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				NAME	RELATIONSHIP	DEPARTMENT	POSITION				
NAME	RELATIONSHIP	DEPARTMENT	POSITION								
HAVE YOU EVER BEEN EMPLOYED BY OUR COMPANY <input type="checkbox"/> YES <input type="checkbox"/> NO - IF YES EMPLOYED FROM _____ TO _____											
POSITION _____		DEPARTMENT _____ IMMEDIATE SUPERVISOR _____									
PLEASE LIST OTHER NAMES USED: (IF NONE, WRITE N/A)											

Employee Initials: _____ Date: _____

EMPLOYMENT SUMMARY

LIST LAST FOUR EMPLOYERS, INCLUDING SUMMER AND PART-TIME POSITIONS WHILE IN SCHOOL. ATTACH SHEET, IF NECESSARY

PRESENT OR MOST RECENT EMPLOYER	FROM	TO
STREET ADDRESS	CITY	(MO. & YR.) STATE ZIP (MO. & YR.)
MAY WE CONTACT THEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, PLEASE EXPLAIN:	
NAME OF SUPERVISOR	TITLE	TELEPHONE NUMBER
JOB RESPONSIBILITIES		
REASON FOR LEAVING		

PRESENT OR MOST RECENT EMPLOYER	FROM	TO
STREET ADDRESS	CITY	(MO. & YR.) STATE ZIP (MO. & YR.)
MAY WE CONTACT THEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEPHONE NUMBER	
NAME OF SUPERVISOR	TITLE	TELEPHONE NUMBER
JOB RESPONSIBILITIES		
REASON FOR LEAVING		

PRESENT OR MOST RECENT EMPLOYER	FROM	TO
STREET ADDRESS	CITY	(MO. & YR.) STATE ZIP (MO. & YR.)
MAY WE CONTACT THEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEPHONE NUMBER	
NAME OF SUPERVISOR	TITLE	TELEPHONE NUMBER
JOB RESPONSIBILITIES		
REASON FOR LEAVING		

PRESENT OR MOST RECENT EMPLOYER	FROM	TO
STREET ADDRESS	CITY	(MO. & YR.) STATE ZIP (MO. & YR.)
MAY WE CONTACT THEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEPHONE NUMBER	
NAME OF SUPERVISOR	TITLE	TELEPHONE NUMBER
JOB RESPONSIBILITIES		
REASON FOR LEAVING		

Employee Initials: _____ Date: _____

EDUCATION AND TRAINING

LIST ALL SCHOOLS ATTENDED	NAME AND ADDRESS OF SCHOOL	NO. YEARS ATTENDED	GRAUDATED (YES OR NO)	DEGREE/DIPLOMA RECEIVED	MAJOR COURSE
HIGH SCHOOL					
COLLEGE OR UNIVERSITY					
GRADUATE SCHOOL					
BUSINESS, TECHNICAL OR OTHER SCHOOLS					

IF YOU ATTENDED COLLEGE BUT DID NOT GRADUATE, HOW MANY UNITS ARE NEEDED TO FULFILL YOUR DEGREE REQUIREMENTS?

NEED _____ ADDITIONAL UNITS FOR A _____ DEGREE IN _____.

ARE YOU PRESENTLY ATTENDING SCHOOL?

NO YES - SCHOOL AND COURSES _____

DO YOU HAVE ANY OTHER EXPERIENCE, TRAINING, EDUCATION, QUALIFICATIONS OR SKILLS PERTAINING TO THE POSITION(S) IN WHICH YOU APPLIED?

LIST ANY SCHOLARSHIPS, ACADEMIC HONORS, AWARDS RECEIVED, OR SPECIAL ACHIEVEMENTS?

LIST ANY LANGUAGES YOU **SPEAK** PROFICIENTLY:

LIST ANY LANGUAGES YOU **READ** PROFICIENTLY:

YOU MAY BE ASKED TO WORK OVERTIME FOR THIS POSITION. ARE YOU ABLE TO DO SO? YES NO

HAVE YOU ESTABLISHED ANY CAREER GOALS? PLEASE EXPLAIN:

PROFESSIONAL SKILLS (IF APPLICABLE)

ARE YOU LICENSED/CERTIFIED FOR THE POSITION(S) IN WHICH YOU APPLIED? YES NO

NAME(S) OF LICENSE/CERTIFICATION(S):

LICENSE/CERTIFICATION NUMBER:

HAS YOUR LICENSE/CERTIFICATION EVEN BEEN REVOKED OR SUSPENDED: YES NO

IF YES, STATE REASON(S), DATE OF REVOCATION OR SUSPENSION AND DATE OF REINSTATEMENT:

CLERICAL SKILLS (IF APPLICABLE)

TYPING _____ WPM ADDING MACHINE OTHER CLERICAL SKILLS, ABILITIES, AND EQUIPMENT OPERATED, PLEASE LIST:

COMPUTER LITERACY
PLATFORMS: PC/IBM MACINTOSH

SOFTWARE PROGRAMS, PLEASE LIST:

**** APPLICANTS: PLEASE COMPLETE ****

ALL APPLICANTS: INITIAL EACH ITEM BELOW AND SIGN THE AGREEMENT.

1. ____ Any acceptance of employment or appointment shall be predicated upon the truthfulness of the statements I have made contained within this application and any supplements required. I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers I gave are 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 omission or misstatement of material fact on this application or on any documents used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery. In either event, DOCS MEDICAL GROUP, INC., will not be held accountable for such actions. I understand that if I am hired that I will provide the company within 3 days of starting work, documents sufficient for verifying identity and authorization to work for completing an I-9 form. I also understand that if I hired I may be required to supply a copy of my current DMV driving license, social security card, all licenses that I hold.
2. ____ I hereby authorize DOCS MEDICAL GROUP, INC. to thoroughly investigate this application and any supplements, my references, work record, education and other matter related to my suitability for employment.
3. ____ I understand that nothing contained in this application, or conveyed during the interview that may be granted or during my employment, if hired, is intended to create an employment with the company.
4. ____ I understand that my application for employment will be placed in an active status for a period of six months during which time it will be reviewed as job openings occur in my area(s) of job interest. I also understand that should I wish to continue to be considered for job openings beyond the six-month period, I must re-apply by submitting a new application for employment.

DATE OF SIGNATURE _____ SIGNATURE (IN INK) _____

We appreciate your interest in DOCS MEDICAL GROUP, INC and the time you have taken to prepare this application.