**WOMEN'S HEALTHCARE AFFILIATES, P. A.**
**APPLICATION FOR EMPLOYMENT**
**(Please Print)**

*Women's Healthcare Affiliates, P. A. is an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including age, sex, color, race, creed, national origin, religious persuasion, marital status, political belief, or disability that does not prohibit performance of essential job functions.*

Date:_______________________________________

**I. Personal Information.**

Name:_______________________________________________________________________
(Last) (First) (Middle Initial)

Present Address:_______________________________________________________________

Permanent Address (if different):_______________________________________________

City:__________________________State________________Zip Code______________

Social Security Number_____________________Telephone__________________________

*Notice: Federal law prohibits the employment of unauthorized aliens. All persons hired must submit satisfactory proof of employment authorization and identity (valid driver's license, birth certificate, Green Card, etc.) within three working days of being hired. Failure to submit such proof within the required time shall result in immediate employment termination.*

Desired Position_______________________________________________________________

1. Is there any information we would need about your name or use of another name for us to be able to check your work record? Please specify:

_____________________________________________________________________________

2. Do you have any relatives who are presently (or have formerly been) employed by Women's Healthcare Affiliates, P.A.?

_____________________________________________________________________________

3. How were you referred to Women's Healthcare Affiliates, P. A.?

_____________________________________________________________________________

4. Have you ever been convicted of a felony? ______Yes _______No If yes, please provide details:

_____________________________________________________________________________

_____________________________________________________________________________

## II. Educational History

| | School Name/Location | Years Completed | Degree/Diploma |
|---|---|---|---|
| High School | | | |
| College | | | |
| Technical Training | | | |
| Other | | | |

## III. Skills

*Please check all those that you have been trained and/or experienced in performing:*

- ☐ Computer Entry
- ☐ Receptionist
- ☐ Medical Terminology
- ☐ Injections
- ☐ Laboratory Assisting
- ☐ Insurance Billing
- ☐ Bookkeeping
- ☐ PBX / Switchboard
- ☐ Drawing Blood
- ☐ Filing
- ☐ Posting EOB's
- ☐ Appointment Scheduling
- ☐ Collections
- ☐ Medical Assisting

## IV. Employment History

*Please include all employment for the past five years. List with most recent employer first.*

1. Company Name_______________________________________________________________

Company Address_______________________________________________________________

______________________________________________________________________________

Position__________________________Dates Employed: From________________to________________

Manager/Supervisor____________________________Telephone Number__________________________

Salary______________per____________ May we contact your current employer? ______Yes______No

Reason for Leaving______________________________________________________________

2. Company Name_______________________________________________________________

Company Address_______________________________________________________________

______________________________________________________________________________

Position__________________________Dates Employed: From________________to________________

Manager/Supervisor____________________________Telephone Number__________________________

Salary______________per____________

Reason for Leaving______________________________________________________________

3. Company Name______________________________________________________________________

Company Address_____________________________________________________________________

____________________________________________________________________________________

Position_____________________________Dates Employed: From__________________to__________________

Manager/Supervisor_______________________________Telephone Number_____________________________

Salary________________per______________

Reason for Leaving___________________________________________________________________

*Note: Use a separate sheet to list additional employers, if necessary. We will contact all of the employers listed on this application unless you specifically exclude them below. Please list any employers you do not want us to contact and your reason for the exclusion:*

Employer's Name_____________________________Reason____________________________________________

Employer's Name_____________________________Reason____________________________________________

## V. References

*Please do not list relatives or friends.*

1. Name______________________________________________________________________________

Address_______________________________________________________________________________

____________________________________________________________________________________

Telephone___________________________Occupation_________________________________________________

2. Name______________________________________________________________________________

Address_______________________________________________________________________________

____________________________________________________________________________________

Telephone___________________________Occupation_________________________________________________

3. Name______________________________________________________________________________

Address_______________________________________________________________________________

____________________________________________________________________________________

Telephone___________________________Occupation_________________________________________________

## VI. Work Availability

1. If your application receives favorable consideration, when will you be available to begin work?

______________________________________________________________________________

2. Do you object to working overtime? ☐ Yes ☐ No
3. Are you able to work overtime without prior notice? ☐ Yes ☐ No
4. Can you work on Saturday? ☐ Yes ☐ No
5. Can you work on Sunday? ☐ Yes ☐ No
6. Can you work on holidays? ☐ Yes ☐ No
7. Can you travel if required by this position? ☐ Yes ☐ No
8. Are you willing to work part-time? ☐ Yes ☐ No
9. Do you prefer full or part time employment? ☐ Full-time ☐ Part-time ☐ Either

## VII. Salary / Hourly Rate Requirements

If your application receives favorable consideration, what salary / hourly rate would you require?

$____________________per ____________

## VIII. Applicant's Certification of True, Correct and Complete Information

I certify that all the statements I made on this application for employment are true, correct, and complete to the best of my knowledge.

Applicant's Signature____________________________________________Date____________________________

## IX. Falsification Statement

I understand that any falsification or willful omission of fact made in this application may be sufficient grounds for rejection of this application, or, if discovered after an offer of employment, or immediate dismissal.

Applicant's Signature____________________________________________Date____________________________

## WOMEN'S HEALTHCARE AFFILIATES, P. A.
## RELEASE FOR BACKGROUND INQUIRY

Please read this section carefully and acknowledge your understanding by signing your name in the space below.

I certify that all of the statements made by me on this application are true, correct, and complete, to the best of my knowledge.

1. Consent to Contact Current and Past Employers.I give permission to Women's Healthcare Affiliates, P.A. to contact all employers listed in this application for references (except those specifically excluded). I further give permission to all current or previous employers and/or managers or supervisors to discuss my relevant personal and employment history with Women's Healthcare Affiliates, P.A., consent to the release of such information orally or in writing, and hereby release them from all liability and agree not to sue them for defamation or other claims based upon any statements they make to any representative of Women's Healthcare Affiliates, P.A. I further waive all rights I may have under state law to receive a copy of any written statement provided by any of my former employers to Women's Healthcare Affiliates, P.A. I further agree to indemnify all past employers for any liability they may incur because of their reliance upon this release.
2. Consent to Conduct Background Inquiry. As a condition of and in consideration for Women's Healthcare Affiliates, P.A.'s consideration of this application, I give permission to Women's Healthcare Affiliates, P.A. to investigate my personal and employment history. I understand that this background inquiry will include, but not be limited to, verification of all information on this application, as well as interviews with past employers. I further give permission to Women's Healthcare Affiliates, P.A. to conduct this inquiry and to discuss the results of this inquiry in connection with my application for employment.
3. Consent to Contact Government Agencies. I give permission to any agent, attorney, or representative of Women's Healthcare Affiliates, P.A. to receive a copy of any information obtained in the file of any federal, state, or local court, governmental agency, law enforcement agency, or investigator concerning or relating to me. I further consent to the release of such information and waive any right under state law concerning notification of the request for a release of such information. In the event a state law does not provide for prospective employers to have access to information, I hereby delegate Women's Healthcare Affiliates, P.A. as my agent for receipt of information. I understand that the scope of this inquiry will be limited to criminal and/or civil records that relate to my honesty, integrity and/or abilities.
4. Cooperation with Inquiry. I agree to fully cooperate in Women's Healthcare Affiliates, P.A.'s background inquiry, and to sign any waivers or releases that may be necessary to obtain access to relevant information. In the event that any former employer or federal, state, or local governmental agency will not release reference information or criminal history information directly tot he employer, I agree to personally request such information to the extent permitted bylaw.
5. Falsification Statement. I understand that any falsification or willful omission of fact made in this application or in connection with any background inquiry may be sufficient grounds for rejection of this application, or, if discovered after an offer of employment, for immediate dismissal.
6. Employment "At Will". In consideration of my employment, I agree to conform to the rules and regulations of Women's Healthcare Affiliates, P.A. and my employment and compensation is "at will" in that they can be terminated with or without cause, and with or without notice, and at any time, at the option of Women's Healthcare Affiliates, P.A. or myself, except as otherwise provided by law.

Applicant's Printed Name________________________________Social Security Number____________________

Applicant's Signature_______________________________________________Date_________________________