



Personal Information

Last Name		First Name		Middle Name	
Street Address		City		State	Zip Code
Telephone Number			Email Address		
Can you legally work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: _____ Offense: _____		

Experience & Skills

Please place a check next to any item you have experience with.

Administrative Skills	Laboratory Skills	Procedures	Patient Care
Typing	Venipunctures	Basic Triage	Temperature
Filing	Finger/Heel Stick	Ear Irrigation	Pulse
Computer Usage	Cultures	EKG	Respirations
Heavy Phones	Urine	Immunizations	Blood Pressure
Medical Terminology	Blood	Injections	Wheelchair Use
Account Collections	Stool	Mammogram	Bandaging
Insurance Filing	Rapid Strep	Ultrasound	Wound Care
Medical Billing	Urinalysis	X-ray	
Appointment Scheduling			

Education

Name of Last High School Attended	Location	Check Last Grade Completed
		<input type="checkbox"/> 9 th <input type="checkbox"/> 10 th <input type="checkbox"/> 11 th <input type="checkbox"/> 12 th
Name of College or Trade School	Location	
Major	Degree/Certification	GPA

--	--	--

Medical Certifications of Licenses

Type of Certification/License	License #	Date Earned	State Issued

Position/Job Information

Date of Application	Position Desired	Preferred Office Location	Date Available

Job Status: <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time Hours Per Week: _____	Check Times you are willing to work: <input type="checkbox"/> Days <input type="checkbox"/> Nights <input type="checkbox"/> Weekends	Are there any times you will NOT be available to work?
Hourly Salary Requirement:	Name and Relationship of Relatives currently working for this practice:	Can your future vacations be arranged at the convenience of the office? <input type="checkbox"/> Yes <input type="checkbox"/> No

Employment Background

Name of Employer	Job Title	Dates of Employment	Length of Employment
Reason for Leaving			

Supervisor's Name	Contact Phone Number	May we contact this employer?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe your Duties and Responsibilities:

Name of Employer	Job Title	Dates of Employment	Length of Employment
Reason for Leaving			

Supervisor's Name	Contact Phone Number	May we contact this employer?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe your Duties and Responsibilities:

Name of Employer	Job Title	Dates of Employment	Length of Employment
Reason for Leaving			

Supervisor's Name	Contact Phone Number	May we contact this employer?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe your Duties and Responsibilities:

I understand the information on this application is subject to verification, and I further understand that any false statements of omissions may be cause for dismissal if hired. I authorize Eagles Landing Family Practice to investigate all statements in this application and conduct a thorough investigation of my past employment, education and job-related activities.

I understand that this application is not a contract of employment and that if hired, the employment between myself and Eagles Landing Family Practice is terminable at any time by myself or ELFP.

Signature of Applicant: _____ Date: _____