



WILDWOOD FAMILY CLINIC, S.C.

"HEALTHCARE FOR ALL AGES"

APPLICATION FOR EMPLOYMENT

PERSONAL

First Name	Middle	Last Name	Social Security Number	
Street Address	City	State	Zip	Hm Ph # Alt Ph #
Are you 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No				

WORK DESIRED

Position / Title	If referred by a current employee, please list employee's full name:		
Are you seeking: <input type="checkbox"/> Full Time (35hrs +) <input type="checkbox"/> Part Time (20-34hrs) <input type="checkbox"/> Limited Hour (10-19hrs) <input type="checkbox"/> Temporary	Earnings desired:	Possible start date:	
	List any days or times you are NOT available to work:		

EDUCATION / TRAINING

SCHOOL NAMES	DATES	DID YOU GRADUATE	DIPLOMA/ DEGREE	MAJOR/DEGREES
High School/GED Location	X X X X X X X X X X			X X X X X X X X X X
College or Technical School Location	From To			
Graduate or Professional School Location	From To			
Other Education / Military Location	From To			
Certificates / Licenses	Year Issued	Exp. Date	License # (if applicable)	
			State	

SKILLS (Check all that apply)

<input type="checkbox"/> Calculator <input type="checkbox"/> Cash Handling <input type="checkbox"/> Credit/Collections <input type="checkbox"/> Call Center <input type="checkbox"/> Telephone Triage	<input type="checkbox"/> Data Entry <input type="checkbox"/> Filing <input type="checkbox"/> Alphabetical <input type="checkbox"/> Numerical <input type="checkbox"/> CPT-4, ICD-9 Codes	<input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medical Terminology <input type="checkbox"/> Medical Transcription <input type="checkbox"/> Switchboard <input type="checkbox"/> Computer/Mainframe	<input type="checkbox"/> Secretarial <input type="checkbox"/> Typing ____ wpm <input type="checkbox"/> Supervisory <input type="checkbox"/> Valid Drivers License <input type="checkbox"/> Health Care	Software Used:
---	--	---	--	----------------

Have you ever been sanctioned by or excluded from participation in any government program including Medicare Medicaid for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain the circumstances of the sanction or exclusion, including when and where it happened, and the name of the agency conducting the investigation.	
Have you ever been discharged or requested to resign from any employment? If yes please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had your professional license or certificate suspended, denied or revoked? If yes please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a crime other than a traffic violation? If yes please list the date(s) and nature(s) of conviction(s): <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please complete all information regardless of submitting a resume or other accompanying materials.

Include any military experience, internship/externship which may relate to the position for which you are applying.

If work or educational experience was obtained under another name, please indicate the name and dates used: _____

May we contact your present employer for a reference? Yes No

EMPLOYMENT HISTORY

Document all work experience below, beginning with your CURRENT or MOST RECENT position.

Employer		Employment Dates: MO/YR			Telephone	
		From:	To:			
Street Address	City	State	Zip	Hm Ph #	Alt Ph #	
Name of Supervisor	Title of Position You Held		Maximum Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Summarize Your Job Duties Below						
Reason for Leaving						

Employer		Employment Dates: MO/YR			Telephone	
		From:	To:			
Street Address	City	State	Zip	Hm Ph #	Alt Ph #	
Name of Supervisor	Title of Position You Held		Maximum Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Summarize Your Job Duties Below						
Reason for Leaving						

Employer		Employment Dates: MO/YR			Telephone	
		From:	To:			
Street Address	City	State	Zip	Hm Ph #	Alt Ph #	
Name of Supervisor	Title of Position You Held		Maximum Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Summarize Your Job Duties Below						
Reason for Leaving						

Employer		Employment Dates: MO/YR From: _____ To: _____			Telephone
Street Address	City	State	Zip	Hm Ph #	Alt Ph #
Name of Supervisor	Title of Position You Held		Maximum Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Summarize Your Job Duties Below					
Reason for Leaving					

Is all previous work experience listed?

Yes No

If no, please attach additional employment history.

I certify that the information on this application is complete, true, and correct. I authorize Wildwood Family Clinic, S.C. to check the references and statements on this application and release it and anyone furnishing information from all liability or damage to me related to the information provided. I understand that I may be required to take a pre-employment physical.

I also understand and agree that if I am employed my employment can be terminated with or without cause or reason and with or without prior notice, at any time, at the option of either Wildwood Family Clinic, S.C. or myself.

I also understand and agree that no one employed by Wildwood Family Clinic, S.C. except the senior executive of my employing entity has the authority to enter in any agreement, whether oral or written, to employ me on any other basis than is stated in the preceding paragraph.

Signature _____

Date _____