APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE

AN EQUAL OPPORTUNITY EMPLOYER

LAST

FIRST

MIDDLE

PERSONAL INFORMATION

NAME (LAST NAME, FIRST)				SOCIAL SECURITY NO.
PRESENT ADDRESS	APPT. NO.	CITY	STATE	ZIP
HOW LONG HAVE YOU BEEN HERE?		HOME PHONE:		
ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO		CELL PHONE:		

DESIRED EMPLOYMENT

POSITION	DESIRED HOURS PER WEEK	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED NOW? ☐ YES ☐ NO		IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ YES ☐ NO	
EVER APPLIED TO THIS COMPANY BEFORE ☐ YES ☐ NO	IF SO, WHEN?		

WHO REFERRED YOU TO THIS COMPANY?

☐ EMPLOYMENT AGENCY ☐ NEWSPAPER ADVERTISING ☐ FRIEND

☐ STATE EMPLOYMENT OFFICE ☐ COLLEGE PLACEMENT SERVICE ☐ WALK IN ☐ OTHER

EDUCATION

SCHOOL LEVEL	NAME / LOCATION OF SCHOOL	NO. OF YEARS ATTENDED	DID YOU GRADUATE?	LICENSE / CERTIFICATES
HIGH SCHOOL			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL			☐ Yes ☐ No	

GENERAL

SPECIAL TRAINING SKILLS

PHYSICAL DISABILITIES OR CHRONIC ILLNESSES

INTERESTS / OUTSIDE ACTIVITIES

FORMER EMPLOYERS

LIST BELOW LAST THREE EMPLOYERS, STARTING WITH THE MOST RECENT ONE FIRST

NAME OF PRESENT OR LAST EMPLOYER						
ADDRESS			CITY		STATE	ZIP
STARTING DATE	LEAVING DATE		JOB TITLE			
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY		MAY WE CONTACT YOUR SUPERVISOR?	☐ YES	☐ NO	
NAME OF SUPERVISOR		TITLE			PHONE	
DESCRIPTION OF WORK						
REASON FOR LEAVING						

NAME OF PREVIOUS OR LAST EMPLOYER						
ADDRESS			CITY		STATE	ZIP
STARTING DATE	LEAVING DATE		JOB TITLE			
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY		MAY WE CONTACT YOUR SUPERVISOR?	☐ YES	☐ NO	
NAME OF SUPERVISOR		TITLE			PHONE	
DESCRIPTION OF WORK						
REASON FOR LEAVING						

NAME OF PREVIOUS OR LAST EMPLOYER						
ADDRESS			CITY		STATE	ZIP
STARTING DATE	LEAVING DATE		JOB TITLE			
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY		MAY WE CONTACT YOUR SUPERVISOR?	☐ YES	☐ NO	
NAME OF SUPERVISOR		TITLE			PHONE	
DESCRIPTION OF WORK						
REASON FOR LEAVING						

REFERENCES

BELOW, GIVE THE NAMES OF THREE PERSONS YOU ARE NOT RELATED TO, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

	NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1		Phone:		
2		Phone:		
3		Phone:		

SERVICE RECORD

BRANCH OF SERVICE	DISCHARGE DATE RANK

HAVE YOU BEEN CONVICTED OF A FELONY WITHING THE LAST 5 YEARS?	☐ YES	☐ NO
IF YES, EXPLAIN (WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION		

AUTHORIZATION

“I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information. ***If applying to our business department, a credit report may be checked.***

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.”

Date Signature

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Parker Pediatrics and Adolescents, P.C. and its authorized representatives or designated agents may investigate the information in this application.

I specifically authorize Parker Pediatrics and Adolescents, P.C. and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this application.

I authorize all individuals, institutions, schools, programs, entities, facilities, companies, agencies, or others with which I have been associated, who may have information bearing on my qualifications to consult with Parker Pediatrics and Adolescents and its authorized representatives and designated agents and to report, release, exchange and share information and documents with Parker Pediatrics and Adolescents for the purpose of evaluating this application and my qualifications.

I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims of whatever nature against Parker Pediatrics and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this application and my qualifications.

I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Please print your name: ______________________________

____
Signature

____
Date