



A • B • C Pediatrics

Adolescents • Babies • Children

Position Desired

- Front Office
- Billing
- Clinical

Employment Application

This application must be completed - Otherwise it will be voided.

Please Print **Personal**

Last Name	First Name	Middle Name	Maiden ame	Social Security Number
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Address No. Street	City-State-Zip	How long?	Telephone Number
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Are you a citizen of the U.S.A.? Yes ___ No ___	Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
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Last 3 physical addresses within 10 years

From - To	Street, City, State, Zip

Prior employment within the past 10 years

Name of Employer	Position	From - To	Starting Wages	Ending Wages

Have you ever been convicted of a violation of the narcotic drug law or laws relating to sexual offenses? Yes No

Have you been convicted of any crime in the past 10 years? Yes No

If you answered yes to either of the above questions, please answer the following:

Date of occurrence: _____ Location: _____ State: _____

Final Outcome: _____

Have you had U.S. military service? Yes ___ No ___	Branch of U.S. Service	Dates of U.S. service	Experience
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Are you a Reservist? Yes ___ No ___	Active?	Inactive?	National Guard?	Other
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Have your wages ever been garnished?	Do you own a car?	
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Father's Name:	Spouse's Name:
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Occupation:	Occupation:
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Employer:	Employer:
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In case of emergency whom should we notify?	Relationship:	Telephone Number:
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Are you willing to work weekends and/or holidays? Yes ___ No ___	Do you realize that it may be necessary for you to work on Saturdays, holidays, or evening clinic? Yes ___ No ___
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The Civil Rights Act of 1964 prohibits discrimination in employment practice because of race, religion, sex, or national origin. "The Age Discrimination in Employment Act of 1967" prohibits discrimination because of age.

This facility is an equal opportunity employer and does not discriminate because of race, sex, religion, age or national origin.

RECORD OF EDUCATION

School	Name and Address of School	Course of Study	Years Attended From - To	Check Last Year Completed	Did you Graduate?	Last Diploma or Degree
ELEMENTARY						
HIGH						
COLLEGE						
OTHER (Specify)						

THIS SECTION TO BE COMPLETED BY PROFESSIONAL AND LICENSED PERSONNEL ONLY

Basic Nursing Preparation

School: Name: _____ Address: _____

Date of Graduation _____ Diploma _____ Degree _____

Are you registered in N.C. Yes ___ No ___ Registration Number: _____

Other state in which registered: _____ Registration Number: _____

Professional Organizations: (Excluding organizations the name or character of which indicates the race, creed, color, or national origin of the members) _____ If Non-member do you plan to join? _____

_____	_____
_____	_____
_____	_____

THIS SECTION FOR TECHNICIANS AND TECHNOLOGISTS ONLY

Are you currently registered in N.C.? Yes ___ No ___	Give number: _____	If not, have you applied? Yes ___ No ___	Date State Board taken in home state: _____	In what other states are you registered _____
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EMPLOYMENT AGREEMENT

I understand that any false statements made as a part of this application will be considered sufficient cause for dismissal. I also grant permission for the authorities of this facility to investigate my references and release said facility from any and all liability resulting from such investigation.

I consent to any and all medical examinations required by the facility and understand that if I am employed I will be on a probationary basis for three months from date of employment. Upon my termination I authorize the release of reference information on my work.

_____ Date

_____ Signature

For ABC Pediatrics Use Only

Received by: _____

Call Placed: _____

Preliminary Interview: Date: _____ Time: _____

Secondary Interview: Date: _____ Time: _____