EAGLES LANDING FAMILY PRACTICE
Providing care at your convenience

Application for Employment

Personal Information

Last Name	First Name	Middle Name

Street Address	City	State	Zip Code

Telephone Number	Secondary Phone Number

Can you legally work in the United States? □ Yes □ No	Have you ever been convicted of a felony? □ Yes □ 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
		□ 9th □ 10th □ 11th □ 12th

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: □ Part-Time □ Full-Time Hours Per Week: _____	Check Times you are willing to work: ☐ Days ☐ Nights ☐ 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? ☐ Yes ☐ 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?
		☐ Yes ☐ 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?
		☐ Yes ☐ 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?
		☐ Yes ☐ 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: _____