Southgate Medical Group

1026 Union Road
West Seneca, NY 14224

This organization is an equal opportunity employer. We consider applications for all position without regard to race, color, religion, creed, gender, national origin, age, disability, marital status, or any other legally protected status.

Position Applied For:

_____

Desired Location: _____ Date: _____

GENERAL INFORMATION

Name *(Last, First, Middle)*: _____

Are you 18 yrs. of age or older? ☐ Yes ☐ No Social Security No. _____

Home Address/Street: _____ Phone No. ( ) _____

City: _____ State: _____ Zip Code: _____

Are you lawfully able to be employed in the USA via Visa or Immigration status? ☐ Yes ☐ No Please indicate type of Visa: _____
(Proof of citizenship or immigration status is required upon employment)

What starting salary will you accept? _____ Date available: _____

Indicate available days and hours: _____ ☐ Part-time ☐ Full-time ☐ PerDiem

Have you ever been convicted of a crime, If so, please explain:

_____

_____

EDUCATION AND TRAINING

HIGH SCHOOL:

Name: _____
Address: _____

Major: _____

COLLEGE:

Name: _____
Address: _____

Major: _____ Number of Years Completed: _____

OTHER EDUCATION:

Name: _____
Address: _____

Major: _____ Number of Years Completed: _____

CHECK YOUR SKILLS:

☐ Typing _____ WPM ☐ Data Entry ☐ Medical Terminology	☐ CPT Coding ☐ Computer ☐ Excel/Lotus Software	☐ Dictaphone ☐ Word Processing ☐ Switchboard	☐ ICD9 Coding ☐ Technical (List)

Please List Skills: _____

Other:

EMPLOYMENT HISTORY (List Most Recent Position First)

From: Mo. Yr.	Name of Employer		Name/Title Supervisor		Telephone No.
To: Mo. Yr.	Street Address, City, State		Position Held		Salary

Briefly describe the work you performed:

Reason for Leaving: _____

If this is your current employer, may we contact? ☐ YES ☐ NO

From: Mo. Yr.	Name of Employer		Name/Title Supervisor		Telephone No.
To: Mo. Yr.	Street Address, City, State		Position Held		Salary

Briefly describe the work you performed:

Reason for Leaving: _____

From: Mo. Yr.	Name of Employer		Name/Title Supervisor		Telephone No.
To: Mo. Yr.	Street Address, City, State		Position Held		Salary

Briefly describe the work you performed:

Reason for Leaving: _____

PROFESSIONAL REFERENCES (Not Personal References)

Name/Occupation	Address	Phone No.
Name/Occupation	Address	Phone No.
Name/Occupation	Address	Phone No.

APPLICANT'S CERTIFICATION

I certify that all matters contained in this application are true, authorize their investigation, and agree that any misleading or false statements would render this application void and would be sufficient cause for immediate dismissal in the event of employment. I understand that my employment is dependent upon satisfactory completion of a physical examination and receipt by this organization and satisfactory references. I understand and agree that my employment is "at will" and for no definite period of time. Either this organization or I can conclude this employment relationship with or without cause. I agree, if employed, to abide by all rules and regulations.

Signature _____ Date _____

PLEASE CHECK YOUR CLINICAL SKILLS:

☐ Allergy Injections	☐ Specialty Areas worked:	☐ Injections
☐ Audiometry	☐ OB/GYN	☐ Spirometry
☐ Blood Collection	☐ Pediatrics	☐ Sterilizing Instruments
☐ Finger Prick	☐ E.R.	☐ Vision Testing
☐ Heal Stick	☐ Medical Floor	☐ Titmus Tester
☐ Hematocrit	☐ Surgical Floor	☐ Snellen Eye Chart
☐ Venipuncture	☐ Surgery	☐ Other
☐ Electrocardiograms	☐ Outpatient	_____
☐ Immunizations	☐ Physician Office	☐ Other clinical skills: Please list:
	(Specialty: _____)	_____
	☐ Other _____	_____
		_____

Are you able perform all the essential functions of the job such as the stress of dealing with people, able to sit, stand or be on the phone all day? _____
Are you able to bend and lift? _____

RELEASE OF REFERENCE INFORMATION

I authorize this organization to contact any schools, employers, law enforcement agencies, and/or persons who may aid the organization in determining my suitability for employment. I release those individuals and/or organizations from all liability whatsoever for issuing the requested information.

My records may also be filed under another name(s):_____

I hereby authorize photocopies of this Reference Release form to be considered valid.

Signature: _____

Date: _____

Disclosure to Employment Applicant
RELEASE AUTHORIZATION

Applicant - please complete the following:

1. In connection with my application for employment, I understand that a background report may be requested that will include information as to my character, work habits, performance, and experience along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job described, you may be requesting information from public and private sources about my worker's compensation injuries, driving record, court record, education, credentials, credit, and references.

   If company policy requires, I am willing to submit to drug testing to detect the use of illegal or habitual drugs prior to and during employment.

2. Medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disability Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and given the name and address of the agency or the source which provided the information.

3. I acknowledge that a fax or photocopy of this shall be as valid as the original. This release is valid for most federal, state, and county agencies.

4. I understand that my employment is dependent upon satisfactory completion of a physical examination (if applicable), background check, and satisfactory references.

5. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference, or insurance company contacted by the employer, or its agent (Healthcare Solutions WNY) to furnish the information described in Section 1.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. I hereby release the employer, its agent and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the requests for or release of any of the above mentioned information or reports.

Please print your full name LAST FIRST MIDDLE

Please print any other names you have used

Current Home Address City State ZIP

Previous Home Address (dates please) City State ZIP

Social Security Number Date of Birth