

Olympic Physicians, PLLC APPLICATION FOR EMPLOYMENT

INSTRUCTIONS: Please furnish all information requested on this form. If you wish to supply additional education or work history information, attach a separate sheet. Please type or print clearly all information.

POSITION APPLIED FOR: _____ **DATE OF APPLICATION** _____

PERSONAL DATA

Name _____ / _____ / _____
Last First Middle Social Security Number

Present Address _____ (____) _____
Street City State Zip Phone Number

Permanent Address _____ (____) _____
Street City State Zip Phone Number

How did you learn about this position? Journal Olympian Friend Other _____

Do you have any relatives employed here? Yes No If yes, please indicate name _____

Have you been previously employed here? Yes No

Have you been convicted of a felony or misdemeanor? Yes No If yes, please explain _____

Have you ever been debarred, excluded or otherwise ineligible for participation in federal or state health programs?

Yes No If yes, please explain _____

Optional

List any foreign language(s) and check the box that best fits your skill level.

Language	Read/Write/Speak	Read/Write	Read/Speak	Read Only	Speak Only

Work Availability

Regular Short-term Full-time Part-time On Call Work Overtime? Yes No

Please indicate the hours you prefer _____

Will you work weekends? Yes No

Indicate days you are available for work

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____

WORK SKILLS

LIST TRAINING AND/OR EXPERIENCE WHICH MAY QUALIFY YOU FOR THE POSITION DESIRED: MARK "T" IF YOU HAVE TRAINING IN THE SKILL, "E" IF YOU HAVE EXPERIENCE IN THE SKILL, MARK "B" IF YOU HAVE BOTH TRAINING AND EXPERIENCE.

	BUSINESS		GENERAL		PATIENT CARE
_____	Typing w.p.m. _____	_____	Autoclave	_____	Sterile technique
_____	Transcription	_____	House Cleaning	_____	Vital Signs
_____	Medical Terminology	_____	Charting	_____	Isolation Technique
_____	Bookkeeping	_____	Filing/Alphabetizing	_____	Urine Catheterization
_____	Accounting	_____	Faxing	_____	EKG
_____	Ten-key adding	_____	Confidentiality	_____	Injections
_____	Calculator			_____	Allergy Shots
_____	Reception			_____	Immunizations
_____	Phone Switchboard			_____	Medication Refills
_____	Insurance Billing			_____	Triage
_____	CPT Coding			_____	Appointment Scheduling
_____	ICD 9 Coding				
_____	Medicare/Medicaid				
_____	Word				
_____	Excel				
_____	Data Entry				
_____	Computers				
_____	Insurance Referrals				

JOB PERFORMANCE ABILITY

Given your knowledge, skills, education and experience, are you able to perform all the essential functions of the position for which you are applying, with or without reasonable accommodation, as set forth in the job description?

Yes No

EDUCATION

High School Attended _____ Diploma GED

College or Schools after High School

Name, Location	Major, Skill, Trade	Dates Attended	Degree or Diploma and Year Graduated

WORK HISTORY

List the most recent employer first. Include at least the past five years, and account for any time gaps in your employment history, including military service. (Attach additional sheet if necessary)

1. Name of employer	Dates employed (mo./yr.) From _____ To _____	Name of Supervisor _____ Phone # _____ May we contact Yes <input type="checkbox"/> No <input type="checkbox"/>
Your last job title and description	Starting Pay _____ Ending Pay _____	Reason for Leaving?
2. Name of employer	Dates employed (mo./yr.) From _____ To _____	Name of Supervisor _____ Phone # _____ May we contact Yes <input type="checkbox"/> No <input type="checkbox"/>
Your last job title and description	Starting Pay _____ Ending Pay _____	Reason for Leaving?
3. Name of employer	Dates employed (mo./yr.) From _____ To _____	Name of Supervisor _____ Phone # _____ May we contact Yes <input type="checkbox"/> No <input type="checkbox"/>
Your last job title and description	Starting Pay _____ Ending Pay _____	Reason for Leaving?
4. Name of employer	Dates employed (mo./yr.) From _____ To _____	Name of Supervisor _____ Phone # _____ May we contact Yes <input type="checkbox"/> No <input type="checkbox"/>
Your last job title and description	Starting Pay _____ Ending Pay _____	Reason for Leaving?

Did you work for any of the above employers under a different name? If so, please list previous name and circle which one(s) 1 2 3 4 5

ATTENDANCE

Do you now have or do you anticipate having any activities, commitments or responsibilities that may prevent you from meeting your work attendance requirements? Yes No

If yes, please explain. _____

PROFESSIONAL REGISTRATION/LICENSURE

Type of Registration or License	State	Number	Date of Expiration

If you do not have a required registration or license, have you applied for one? Yes No

Has your license ever been revoked, suspended, or denied? If yes, please explain. _____

Have you ever had any malpractice claims filed against you? If yes, please explain. _____

EMPLOYEE CONSENT

I certify that the above information in this application for employment is true and complete to the best of my knowledge. I understand that, if employed, falsified statements on this application or failure to furnish all requested information shall be considered sufficient cause for dismissal.

I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the Immigration Reform and Control Act of 1986. I further understand that my employment is contingent upon the checking of references furnished by me, and contingent upon a background check performed by a third party, for any criminal offenses.

I consent to and authorize this employer and its personnel to request any information concerning my previous employment record as indicated on this application for employment. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such job related information.

I understand and agree that my employment and compensation may be terminated at any time without prior notice, with or without cause, at the option of the company or myself, and understand that no representative of the company other than the owner has the authority to enter into any agreement contrary to the forgoing. I understand that my employment will include a ninety day probation period which will result in closer scrutiny of my performance but does not alter the fact that after such probationary period my employment remains one at-will and may be terminated at any time with or without cause. Further I acknowledge that any statement herein that warns of dismissal as a result of some violation does not alter my at-will employment status but is only intended to emphasize consequences for violations.

I understand that Olympic Physicians is a smoke free environment and that there is no smoking on Olympic Physicians property. I also understand and consent to a random drug sample from me at the request of Olympic Physicians. I also understand that a positive drug test may lead to immediate dismissal.

I consent and agree to a criminal background check through the Washington State Patrol at the discretion of the employer. I agree to complete the form when requested by the employer. I understand that if an unsatisfactory report is received I will be terminated.

I understand that all company property must be returned and any indebtedness to the company must be paid on or before my last day of work. I authorize the company to deduct from my final paycheck an amount necessary to satisfy any unpaid obligation.

Signature of Applicant

Date

RELEASE AUTHORIZATION

In connection with my application for employment with you, I understand that an investigative consumer 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 from previous employers. Further, I understand that you will be requesting information concerning my workers' compensation claims, motor vehicle operation history, credit history and criminal history from various states, private and insurance sources along with other public records available. Worker's compensation information will only be requested in compliance with the ADA and/or any other applicable state laws.

I HERBY AUTHORIZE, WITHOUT RESERVATION, ANY LAWFUL ENFORCEMENT AGENCY, ADMINISTRATOR, STATE AGENCY, INSTITUTION, INFORMATION SERVICE BUREAU, EMPLOYER OR INSURANCE COMPANY CONTACTED BY ORCA INFORMATION, INC TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I further acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original. This release includes all state and federal agencies including Minnesota's Department of Labor. 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 so advised and be given the name of the agency or source of information.

Today's Date: _____ Signature: _____

The following must be filled out completely for your application to be considered. (Please print).

Last Name	First Name	MI	Date of Birth	Race	Sex	Social Security #	
Place of Birth (City/State)	Current Address		City	State	Zip	Driver's License # / St	
Other Last Names Used	Other States and Counties I have lived in as an adult...		State	County	Zip	From (year)	To (year)
		1					
		2					
		3					
		4					

Have you ever been charged or convicted of a crime: Yes No

If yes, what State & County: _____ **what was the nature of the crime (give details):**

***The above information is to be used only for identification and investigative purposes.**

This information is being verified by ORCA Information, Inc. Any information or questions should be directed to the following address:

ORCA Information, Inc.
P.O. Box 277
Anacortes, WA 98221
(800) 341-0022 (360) 588-1633

