

Applicants Name _____

Date _____

Position Applied for _____

Received _____

EMPLOYMENT APPLICATION



Family Healthcare of Hagerstown

201 S. Cleveland Avenue
Hagerstown, MD 21740
301-745-3777
301-393-3476 (fax)

We are an equal opportunity employer. We do not discriminate on the basis of race, religion, color, age, national origin or disability.

PERSONAL

Name _____ Social Security # _____
Last, First Middle

Address _____ Phone # _____

City/State/Zip Code _____ Cell # _____

Email Address _____

Position Applied for _____ Desired Salary \$ _____

Full Time _____ Part Time _____ Flex Staff _____ Date available to begin work _____

Do you have any relatives employed at Family Healthcare of Hagerstown?
_____ No _____ Yes Department _____ Please list _____

Have you ever been employed here before? _____ If so, when? _____

Are you under the age of 18? _____ Yes _____ No Are you legally entitled to work in the United States?
_____ Yes _____ No

Were you ever convicted of a crime? _____ No _____ Yes
If yes, explain: _____

A record of a criminal conviction will not necessarily bar you from employment. In making our decision, we will consider many factors, such as the age and time of the offense involved, the seriousness and nature of the violation, and whether you have been rehabilitated. We will also consider the nature of the job for which you are applying.

EDUCATION/SKILLS

School	Name & Address of School	Course of Study	Mark Year Completed	Did you graduate?	List Diploma or Degree
High			9 10 11 12		
College			1 2 3 4		
College			1 2 3 4		

Other training or special courses (including computer skills) _____
_____ Typing Approx WPM _____

Areas of specialization or major interest _____

List healthcare, business or industrial equipment operated _____

Professional licenses and/or certifications
Are you currently: _____ Registered _____ Licensed _____ Certified
Are you eligible for: _____ Registration _____ Licensure _____ Certification

If licensed, registered or certified:
Type _____ State Issued _____ Expiration Date _____ Number _____
Type _____ State Issued _____ Expiration Date _____ Number _____

Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example: Medicare, Medicaid)? _____ Yes _____ No
Have you ever been the subject of any investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? _____ Yes _____ No
Within one year prior to the date of this application, have you been employed by any of the following agencies? (check all that apply)
_____ Maryland Medicaid (Medical Assistance) _____ Maryland Medicaid Fraud Control Unit _____ Wellmark, Inc.
_____ Maryland Medicare Part A (Blue Cross/Blue Shield) _____ Administar Federal _____ Trailblazers, Inc.

MILITARY RECORD

Were you in the US Armed Forces? _____ Yes _____ No Branch of Service _____ From _____ To _____
Do you have any experience from your military service that would be relevant to the job(s) for which you are applying? _____ Yes _____ No
Rank at discharge _____ Selective Service Class _____

EMPLOYMENT HISTORY

List current position first, then next previous in order.

If any employment was under a different name, indicate name _____

1) Name of Company _____ Type of Business _____

Address _____

Job Title _____ Date Hired _____ Last Date _____

Reason for Leaving _____ Voluntary _____ Involuntary _____ May we communicate with this employer?

(Explain) _____ Yes _____ No

Name and Phone # of immediate supervisor (include title) _____

Description of duties _____

2) Name of Company _____ Type of Business _____

Address _____

Job Title _____ Date Hired _____ Last Date _____

Reason for Leaving _____ Voluntary _____ Involuntary _____ May we communicate with this employer?

(Explain) _____ Yes _____ No

Name and Phone # of immediate supervisor (include title) _____

Description of duties _____

3) Name of Company _____ Type of Business _____

Address _____

Job Title _____ Date Hired _____ Last Date _____

Reason for Leaving _____ Voluntary _____ Involuntary _____ May we communicate with this employer?

(Explain) _____ Yes _____ No

Name and Phone # of immediate supervisor (include title) _____

Description of duties _____

Have you ever been discharged from any employment or asked to resign? _____ No _____ Yes, please explain _____

Are there any family, personal, business or other reasons that would prevent you from performing in a consistent manner? ____ Yes ____ No If yes, please comment _____

Please list and describe any paid or unpaid activities, honors, experience, or training that might aid you in performing the job(s) for which you have applied and have not listed previously. (You may omit any activities, honors, memberships or other items that tend to identify your race, sex, national origin, age, disability or other personal traits you prefer not to disclose.) _____

Please add any additional information (except that which identifies your race, sex, age, religion, national, origin, disability or other non-job related personal information) that you think may be relevant to a decision to hire you.

I have read and understand the following statement: **"UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND ANY APPLICANT FOR EMPLOYMENT OR PROSPECTIVE EMPLOYMENT OR ANY EMPLOYEE TO SUBMIT TO OR TAKE A POLYGRAPH, LIE DETECTOR OR SIMILAR TEST OR EXAMINATION AS A CONDITION FOR EMPLOYMENT OR CONTINUED EMPLOYMENT. ANY EMPLOYER WHO VIOLATES THIS PROVISION IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT TO EXCEED \$100.00."**

Signature _____ Date _____

NOTICE: The Family Healthcare of Hagerstown has a general preference for "non-smokers."

AGREEMENT

I hereby affirm that all statements made herein are true and correct to the best of my knowledge. I authorize Family Healthcare of Hagerstown to conduct whatever evaluation they deem necessary to confirm statements submitted on this application. If the evaluation determines any untrue statements are made, I understand this may be sufficient grounds for immediate dismissal.

I authorize Family Healthcare of Hagerstown and also authorize and request each former employer and person, firm and corporation given as a reference to answer any and all questions that may be sought in connection with this application.

I agree to submit myself, upon request, for a physical examination by Family Healthcare of Hagerstown and understand that employment is subject to meeting medical standards. In addition, if accepted for employment I hereby agree to abide by the rules and policies of my employer.

I understand that Family Healthcare of Hagerstown's mission is to serve the needs of the patients and that changes of hours/shifts/weekends may be required to meet these needs.

I understand that nothing contained on this employment application is intended to create an employment contract between Family Healthcare of Hagerstown and myself for either employment or the providing of any benefit. No promises regarding employment have been made to me. If an employment relationship is established, I understand that my employment will be at will, and that Family Healthcare of Hagerstown has the right to terminate my employment at any time for any reason.

Signature _____ Date _____