THIS CLINIC IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE BECAUSE OF AGE, SEX, RACE, CREED, COLOR, NATIONAL ORIGIN, HANDICAP OR DISABILITY

APPLICATION FOR EMPLOYMENT

PERSONAL DATA

DATE:_____

NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY NO. / BIRTHDATE (DAY & MONTH)
ADDRESS	STREET	CITY	STATE ZIP	PHONE AREA CODE / NUMBER
PERMANENT ADDRESS	STREET	CITY	STATE ZIP	ALTERNATE PHONE AREA CODE / NUMBER

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THIS COUNTRY? ◯ YES ◯ NO
(PROOF OF U.S. CITIZENSHIP OR IMMIGRATION STATUS WILL BE REQUIRED UPON EMPLOYMENT)

HAVE YOU EVER BEEN CONVICTED OF A FELONY, OR PLED GUILTY OR NO CONTEST TO A FELONY? ◯ YES ◯ NO
IF YES, EXPLAIN (A YES RESPONSE DOES NOT NECESSARILY PRECLUDE CONSIDERATION FOR HIRING.)

ARE YOU ABLE TO MEET ATTENDANCE REQUIREMENTS OF THE POSITION? ◯ YES ◯ NO

DO YOU HAVE RELATIVES WORKING FOR THIS CLINIC? ◯ YES RELATIONSHIP? ◯ NO

JOB PREFERENCE

POSITIONS APPLYING FOR IN ORDER OF PREFERENCE
1. 2. 3.

TYPE OF EMPLOYMENT DESIRED
☐ REGULAR ☐ FULLTIME ☐ PART-TIME

ARE YOU WILLING TO WORK WEEKENDS AND/OR HOLIDAYS? ◯ YES ◯ NO	WHAT IS YOUR WAGE/SALARY REQUIREMENT?
WHEN WILL YOU BE AVAILABLE TO BEGIN WORK?	HAVE YOU EVER WORKED HERE BEFORE? (◯) YES (◯) NO

EMPLOYMENT HISTORY

STARTING WITH PRESENT OR MOST RECENT EMPLOYER, LIST PREVIOUS EMPLOYMENT

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	( )RESIGNED ( ) DISCHARGED REASON:	

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	( )RESIGNED ( ) DISCHARGED REASON:	

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
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EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	( )RESIGNED ( ) DISCHARGED REASON:	

EDUCATION AND TRAINING

SELECT LAST GRADE COMPLETED: GRAMMAR: Select One HIGH SCHOOL: Select one COLLEGE: None

NAME OF COLLEGE/UNIVERSITY	DEGREE	MAJOR/FIELD		DATE GRADUATED
VO-TECH (Including Nursing)	CERTIFICATE/LICENSE	MAJOR/FIELD		DATE GRADUATED
BUSINESS SCHOOL/SPECIAL TRAINING	DEGREE/CERTIFICATE	MAJOR/FIELD		DATE GRADUATED
TYPE OF LICENSE IF MEMBER OF TRADE OR PROFESSION	LICENSE NO.	ISSUING DATE	EXPIRATION DATE	LIC. VERIFIED BY/DATE

MACHINES AND EQUIPMENT YOU CAN OPERATE	PAST ELECTRONIC MEDICAL HEALTH RECORDS EXPERIENCE PLEASE LIST:

MILITARY SERVICE

BRANCH	DATES OF SERVICE FROM TO	DESCRIBE MILITARY OCCUPATION/EXPERIENCE

SOURCE INFORMATION

PLEASE CHECK THE ITEM BELOW WHICH BEST DESCRIBES WHY YOU ARE APPLYING HERE:

- ☐ ANSWERED NEWSPAPER AD
- ☐ RECOMMENDED BY A FRIEND/RELATIVE
- ☐ CONTACTED BY RECRUITER
- ☐ OKLAHOMA STATE EMPLOYMENT SERVICE
- ☐ REPUTATION OF OKLAHOMA ALLERGY & ASHTMA CLINIC
- ☐ WALK-IN APPLICANT
- ☐ OTHER, EXPLAIN

EMPLOYMENT AGREEMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I testify that all answers given in this application are true and correct to the best of my knowledge and belief. I understand that any omission or misrepresentation will disqualify my application or be cause for dismissal. I also authorize the authorities of the Oklahoma Allergy and Asthma Clinic to investigate all statements and references and release the Clinic from any and all liability resulting from such investigation. I consent to medical examinations or other tests required for the position I am applying for and understand that if I am employed, I will be on a provisional basis for 180 days from the date of employment. Upon termination, I authorize the release of reference information on my work. I also agree, if employed, to serve to the best of my ability and to abide by the policies established by Clinic administration. I understand that this application for employment by this Clinic does not constitute an employment contract. Should employment occur, either party at any time with or without notice, and with or without cause, may terminate the relationship.

SIGNED:----------DATE: ----------

APPLICANT __ DO NOT FEEL BELOW THIS LINE

SUPERVISOR/DEPARTMENT HEAD

MO/DAY/YEAR STARTING	DEPARTMENT	POS. TITLE	WAGE / SALARY /Per
◯REGULAR ◯FULLTIME ◯PART-TIME			HOURS/DAYS OF WEEK
SIGNATURE OF SUPERVISOR	SIGNATURE OF DEPARTMENT HEAD	SIGNATURE OF EXECUTIVE DIRECTOR	

Please review your application before submitting, by clicking the submit bottom this application will be emailed to us.

Submit