



Medical Clinic  
785-825-7251

Dental Clinic  
785-826-9017

Pharmacy  
785-452-3900

Fax  
785-825-6887

## APPLICATION FOR EMPLOYMENT

Position applied for: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail: \_\_\_\_\_

Are you legally eligible for employment in the United States? ☐ Yes ☐ No

*(Under the Immigration Reform and Control Act of 1986, you will be required to provide documentation to certify your eligibility and identity, should you be employed.)*

Employment Preference: ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Other

Date Available: \_\_\_\_\_

Days Available: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Hours Available: ☐ Day ☐ Evening ☐ Night ☐ Rotating ☐ Weekends

Specify Shift Hours (if any): \_\_\_\_\_

Salary Desired: \_\_\_\_\_

Do you have any relatives employed at SFHC? ☐ Yes ☐ No If yes, whom? \_\_\_\_\_

Have you ever filed an application with us? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

May we contact your current employer? ☐ Yes ☐ No

May we contact your previous employer? ☐ Yes ☐ No If not, why? \_\_\_\_\_

### RECORD OF EMPLOYMENT (Beginning with your most recent employer)

1.	
Name of Employer: _____	
Address: _____	
Telephone: (____) - _____	Your Position: _____
Dates Employed (mm/dd/yyyy): From ____/____/____ To ____/____/____	
Rate of Pay: Starting _____ Ending _____	
Reason for Leaving: _____	
Supervisor's Name and Title: _____	
Your Duties: _____	

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) - \_\_\_\_\_ Your Position: \_\_\_\_\_

Dates Employed (mm/dd/yyyy): From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Rate of Pay: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Your Duties: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) - \_\_\_\_\_ Your Position: \_\_\_\_\_

Dates Employed (mm/dd/yyyy): From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Rate of Pay: Starting \_\_\_\_\_ Ending \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Your Duties: \_\_\_\_\_

## EDUCATION

	Name	Major	Level Completed	Did you Graduate?	Degree
High School				<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (specify)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## TECHNICAL SKILLS

### Microsoft Office Applications

Word Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Excel Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Outlook Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

PowerPoint Proficiency - ☐Expert ☐Intermediate ☐Beginner ☐ No Experience

Do you have experience with any of the following?

AthenaHealth ☐ Yes ☐ No Dentrix ☐ Yes ☐ No PioneerRX ☐ Yes ☐ No

Other Applications you have experience in: \_\_\_\_\_

Special Credentialing, Certifications or Professional Licensing: \_\_\_\_\_

Additional Skills or Qualifications: \_\_\_\_\_

\_\_\_\_\_

**WORK REFERENCES**

Name:	Name:
Company:	Company:
Address:	Address:
Phone:	Phone:

Have you read and do you understand the duties and responsibilities of this position?    ☐ Yes    ☐ No

Is there any reason why you could not perform all the described duties associated with this position?    ☐ Yes    ☐ No

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

*I hereby certify that the information provided in this application along with its attachments, are true and complete. I also agree and understand that any falsification of information herein, regardless of time of discovery, may result in the forfeit of my employment with this organization. I understand that all information in this application is subject to verification and I consent to any criminal history background checks. I also authorize this organization to contact my references, educational institutions, or any other person or organization that may have information relevant to my employment. I further authorize the organization to rely upon and use as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, non-governmental organizations or systems on a need-to-know basis for good cause shown as determined by the agency head or designee.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_