

EMPLOYMENT APPLICATION

Please Print In Black Ink

Date: _____

Position(s) Applying For: _____			Date Available to work: _____		
NAME: LAST		FIRST	MIDDLE		
ADDRESS		CITY	STATE	ZIP CODE	
HOME PHONE NUMBER	MESSAGE/BUSINESS PHONE NUMBER		EMAIL		
If hired, can you furnish proof that you are eligible to work in the U.S.A.? (UPH participates in E-Verify) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain _____					
If hired, can you furnish proof that you are at least 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you ever been convicted of a crime? (misdemeanor, felony, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, month and year _____ Specific Charge _____ A conviction does not automatically mean you cannot be hired. What you were convicted of, how old the conviction is, and the nature of the job you are applying for are important. Give all the facts so that a decision can be made.					
Have you ever been or are you currently the subject of an investigation, suspension or sanction from participating in any private, federal or state health insurance program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes -- please explain: _____ _____ _____					
Have you ever been interviewed for a job with UPH? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list interviewer name and approximate date _____					
Have you ever been employed by University Physicians Healthcare/University Physicians, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list department, dates of employment, and name employed under _____					
Do you have relatives working for UPH? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name, Relationship, Department: _____ _____ _____					
How were you referred to UPH? _____ _____					

Work schedule desired (or willing to accept)		Available to work:			
<input type="checkbox"/> Regular full time	<input type="checkbox"/> Temporary	Evenings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Saturday	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Regular part time	<input type="checkbox"/> Per Diem	Nights	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sunday	<input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION	Name of School	Address	Major	Circle Last Year Completed	Degree
HIGH SCHOOL/GED	_____	_____	_____	1 2 3 4	_____
	_____	_____	_____		_____
COLLEGE OR UNIVERSITY	_____	_____	_____	1 2 3 4	_____
	_____	_____	_____		_____
	_____	_____	_____		_____
ADDITIONAL EDUCATION TECHNICAL BUSINESS PROFESSIONAL	_____	_____	_____	1 2 3 4	_____
	_____	_____	_____		_____
	_____	_____	_____		_____

ALL PROFESSIONAL REGISTRATIONS, LICENSES OR CERTIFICATIONS YOU HOLD OR HAVE EVER HELD.

TYPE	ISSUING DATE	REGISTRATION #	EXPIRATION DATE	CURRENT

Complete all areas for the last ten (10) years of employment

EMPLOYMENT HISTORY: <small>Start With Most Current</small> Attach additional sheet if needed. Account for periods of unemployment			
EMPLOYER NAME		TELEPHONE#	
ADDRESS	CITY	STATE	ZIP
POSITION HELD	DATES OF EMPLOYMENT: FROM		TO
STARTING SALARY	ENDING SALARY		
NAME AND TITLE OF SUPERVISOR			
TELEPHONE# / E-MAIL ADDRESS		MAY WE CONTACT?	YES NO
NUMBER OF HOURS WORKED WEEKLY	REASON FOR LEAVING		
DESCRIPTION OF DUTIES AND RESPONSIBILITIES:			

ACCOUNT FOR PERIODS OF UNEMPLOYMENT From: _____ To: _____ Reason: _____

EMPLOYER NAME		TELEPHONE#	
ADDRESS	CITY	STATE	ZIP
POSITION HELD	DATES OF EMPLOYMENT: FROM		TO
STARTING SALARY	ENDING SALARY		
NAME AND TITLE OF SUPERVISOR			
TELEPHONE# / E-MAIL ADDRESS		MAY WE CONTACT?	YES NO
NUMBER OF HOURS WORKED WEEKLY	REASON FOR LEAVING		
DESCRIPTION OF DUTIES AND RESPONSIBILITIES:			

ACCOUNT FOR PERIODS OF UNEMPLOYMENT From: _____ To: _____ Reason: _____

EMPLOYER NAME		TELEPHONE#	
ADDRESS	CITY	STATE	ZIP
POSITION HELD	DATES OF EMPLOYMENT: FROM		TO
STARTING SALARY	ENDING SALARY		
NAME AND TITLE OF SUPERVISOR			
TELEPHONE# / E-MAIL ADDRESS		MAY WE CONTACT?	YES NO
NUMBER OF HOURS WORKED WEEKLY	REASON FOR LEAVING		
DESCRIPTION OF DUTIES AND RESPONSIBILITIES:			

ACCOUNT FOR PERIODS OF UNEMPLOYMENT From: _____ To: _____ Reason: _____			
EMPLOYER NAME		TELEPHONE#	
ADDRESS	CITY	STATE	ZIP
POSITION HELD	DATES OF EMPLOYMENT: FROM		TO
STARTING SALARY	ENDING SALARY		
NAME AND TITLE OF SUPERVISOR			
TELEPHONE# / E-MAIL ADDRESS		MAY WE CONTACT?	YES NO
NUMBER OF HOURS WORKED WEEKLY	REASON FOR LEAVING		
DESCRIPTION OF DUTIES AND RESPONSIBILITIES:			

ADDITIONAL SKILLS:	CHECK IF APPLICABLE
<input type="checkbox"/> TYPING (SPEED) _____	<input type="checkbox"/> TRANSCRIPTION (SPEED) _____
<input type="checkbox"/> COMPUTER _____	<input type="checkbox"/> MEDICAL TERMINOLOGY _____
<input type="checkbox"/> WORD PROCESSING (SYSTEM) _____	<input type="checkbox"/> TEN KEY BY TOUCH _____
<input type="checkbox"/> OTHER JOB RELATED SKILLS _____	<input type="checkbox"/> OTHER SOFTWARE SYSTEM _____
<input type="checkbox"/> AUTOMATED APPOINTMENT SCHEDULING _____	
 LANGUAGES:	
SPANISH:	<input type="checkbox"/> SPEAK <input type="checkbox"/> READ <input type="checkbox"/> WRITE
OTHER LANGUAGE: _____	<input type="checkbox"/> SPEAK <input type="checkbox"/> READ <input type="checkbox"/> WRITE
PLEASE PROVIDE US WITH ANY ADDITIONAL INFORMATION WHICH WOULD BE HELPFUL AND RELEVANT TO THIS APPLICATION SUCH AS ADDITIONAL SKILLS, JOB-RELATED COURSES, ACHIEVEMENTS, ETC.	

REFERENCES: Please list the names of three references who you have worked with and who are familiar with your work history.

NAME	TITLE	COMPANY	PHONE NUMBER
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Do we have permission to contact the references listed above? Yes No

I understand that any employment or offer of employment arising from this application will be subject to satisfactory verification of all job qualifications which may include academic credentials, licenses, professional designation and employment history.

I authorize University Physicians Healthcare to consult with representatives, employees, agents and others of institutions with which I have been associated and with others who may have information relating to this application, either in writing or verbally. I release from liability all such persons who give this information in good faith and without malice.

The information contained in this employment application is true and accurate and contains no misrepresentation or falsification. I understand that if I become employed, any misrepresentation of facts of this employment application is cause for dismissal.

Applicant's Signature

Date

UNIVERSITY PHYSICIANS HEALTHCARE CONSENT FOR DRUG SCREENING

I understand and acknowledge that University Physicians Healthcare (UPH) hires and retains only those individuals who are not impaired by alcohol, drugs or controlled substances and that UPH requires all applicants (post offer, pre-hire) for employment to submit to chemical testing and analysis for the detection of controlled substances as part of the applicant's pre-employment physical examination. I also understand and acknowledge that as part of my pre-employment physical examination and during the course of employment I am required to submit one or more samples of my blood and or urine for such chemical testing and analysis.

I consent to, authorize and direct the collection and chemical testing of these samples for the purpose of detecting drugs, alcohol or controlled substances. I further consent to, authorize and direct the release of any and all information including but not limited to, results of any chemical testing and analysis to UPH, its officers, agents, employees, independent contractors and affiliates, to be used for the purpose described above.

I understand and acknowledge that if any chemical testing or analysis of my urine reveals the presence of controlled substances, I will be disqualified from further consideration. I understand and acknowledge that my failure to appear as scheduled for any chemical testing and analysis will result in the withdrawal of my application or the termination of employment. I will not be eligible to make application for employment with UPH now or for twelve months subsequent to the date of my pre-employment physical examination.

Applicant's Name (Please Print)

Applicant's Signature

Date

CONDITIONS OF EMPLOYMENT

University Physicians Healthcare will make efforts to accommodate schedules and work assignments. Due to the nature of healthcare, organizational changes, and public safety, you may be required to work in the areas not originally assigned for which you are qualified or assume periodic changes in the work schedule. These conditions of employment are listed below:

1. I may be required to assist in other areas for which I am qualified if the need arises;
2. I will rotate to other shifts when necessary;
3. I will work weekends and holidays when assigned;
4. I will have a telephone or message contact number listed in the department during my employment;
5. I will work overtime when requested by the supervisor;
6. I will have a pre-employment health assessment and a pre-employment drug screen and periodic health assessments as required by my department and will comply with all Employee Health policies and the alcohol and drug free work place policy;
7. I give University Physicians Healthcare the authority to deduct the value of any UPH property or monies owed to UPH from my paycheck as allowed by law;
8. I understand that I have no contractual employment agreement, that this document nor any personnel policy constitutes an employment contract and that my employment can be terminated at any time by University Physicians Healthcare.

Applicant's Signature

Date

Dear Applicant,

In connection with your application with University Physicians Healthcare, please note that if you are a final candidate for a position with our organization, a consumer report may be requested that may include information regarding your character, along with reasons for termination of past employment from previous employers. This information may include motor vehicle operation history and criminal history from various state, private and insurance sources along with other public records available. Please sign below to indicate your acknowledgement of this notice of intent to verify background information and complete the attached form. We appreciate your cooperation, as UPH strives to ensure that those with whom we work are the best match for our commitment to excellence.

Applicant Name (printed) _____

Applicant Signature _____

Date _____

RELEASE AUTHORIZATION

This document authorizes this employer, or its research agent, to seek and/or verify specific information about my background. I understand that this authorization applies whether I am a current employee, a candidate for employment, or seeking to provide services as an independent contractor. I understand that this release authorization will remain in effect for the duration of my employment unless I revoke this release authorization in writing.

I specifically authorize that background information may be sought in the following areas, and agree to release from any liability the agencies, prior employers, individuals or other entities which provide the information to the client to the extent that the information given is true and accurate:

- a. Criminal conviction records in any jurisdiction;
- b. Social Security Number Trace Report;
- c. Driving record in any state;
- d. Educational and Professional Certification records in any jurisdiction;
- e. Work Performance, attendance, and job related information.

I agree to assist in this effort by contacting former employers and asking for full exposure of my employment history.

I further understand that information obtained may be used by this employer in its sole discretion and without liability to determine eligibility for initial or continued employment, to grant or deny me permission to enter into employer property, or that of its affiliated companies. I further understand that this information will become part of my personnel record at this employer and will be held in the confidence accorded all such records.

I acknowledge that I have read and understand this information, that the rules governing its collection and use are pursuant to the Fair Credit Reporting Act as amended by the Consumer Credit Reform Act of 1996, and that any adverse action based on this information will be communicated to me in accordance with the Act.

This information is being verified by SECURITECH, INC. Any information or questions should be directed to the following address:

SECURITECH, INC.
8230 E. Broadway Suite #E-10
(520) 721-0305
FAX (520) 721-7706

SIGNATURE

TODAY'S DATE

PLEASE PRINT: The following must be filled out completely for your application to be considered. Provide your home address for the last seven (7) years. If necessary, use the backside of this form.

LAST NAME FIRST NAME MIDDLE INITIAL

OTHER NAMES BY WHICH YOU HAVE BEEN KNOWN AND DATES THOSE NAMES WERE USED

HOME ADDRESS CITY, STATE ZIP DATES LIVED THERE

CITY, STATE ZIP

SOCIAL SECURITY NUMBER DATE OF BIRTH

DRIVER'S LICENSE NUMBER STATE OF DRIVER'S LICENSE ISSUE

APPLICANT – DO NOT WRITE BELOW THIS LINE

SUBSCRIBER CODE: UNI0575 KIN2800

 BASIC EMPL MVR OOT – CRIM OOT- EMPL REF ED VER CERT VER +75K SEX OFF OIG

OTHER INFORMATION REQUESTED: _____

See Over



APPLICANTS,

PLEASE LIST PREVIOUS ADDRESSES (MOST RECENT FIRST) COVERING THE PAST 7 YEARS:

1.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

2.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

3.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

4.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

5.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

6.

Street Address	City	State	Zip
----------------	------	-------	-----

Country (if known)	From: Month/Year	TO: Month/Year
--------------------	------------------	----------------

EMPLOYMENT APPLICATION SUPPLEMENT

Have you ever been or are you currently the subject of an investigation, suspension or sanction from participating in any private, federal or state health insurance program?

Yes --If yes, please explain: _____

No

Applicant's Name (Please Print)

Applicant's Signature

Date

Note: this supplement is to filed with the employment application.

SUPPLEMENTAL APPLICATION DATA

In order to comply with Affirmative Action requirements, we have a program of application information research. This information will provide data in evaluating our recruitment and selection procedures. Nothing provided below will be used in any way whatsoever to affect your application, rating or employment, nor will it be supplied to the hiring authority. Your response is voluntary and will not jeopardize or adversely affect any consideration you might receive for employment.

THIS ENTIRE FORM WILL BE REMOVED FROM YOUR APPLICATION PRIOR TO THE EVALUATION OF YOUR QUALIFICATIONS BY THE HIRING AUTHORITY.

PLEASE PRINT

Name: _____

Sex: Male Female

Position Applied For: _____

Date of Birth: _____

HOW DID YOU FIRST HEAR ABOUT THIS POSITION?

- | | | |
|---------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Professional Trade Journal | <input type="checkbox"/> Outreach Recruitment Site |
| <input type="checkbox"/> UPH Employee | <input type="checkbox"/> UPH Human Resources | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> DES | <input type="checkbox"/> Other _____ | |
-

RACE OR ETHNICITY

- WHITE** (not Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.
- BLACK** (not Hispanic Origin): Persons having origins on any Black racial groups of Africa.
- HISPANIC**: Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture origin.
- ASIAN**: Persons having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent. This area includes for example, China, Japan and Korea.
- AMERICAN INDIAN OR ALASKAN NATIVE**: Persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: Persons having origins in any of the original peoples of the Pacific Islands. This area includes for example, the Philippine Islands and Samoa.
-

University Physicians Healthcare complies with the Americans with Disability Act. If you wish to claim status as a disabled applicant, indicate this by checking the item below:

- DISABLED INDIVIDUAL**: A person who: (a) has a physical or mental impairment which substantially limits one or more major life activities; (b) has a record or such an impairment, or (c) is regarded as having such an impairment. I will need the following accommodation(s) made in order to perform the functions of the job applied for:
- _____

If you are a Disabled Veteran or a Vietnam Era Veteran, as defined below, please indicate this by checking the appropriate definition below:

- DISABLED VETERAN**: A person entitled to disability compensation under the Veteran Administration with a 30% or more disability, or a person discharged or released from active duty for a disability incurred or aggravated in the line of duty.
- VETERAN OF THE VIETNAM ERA**: A person who served on active duty for a period of more than 180 days, any part of which occurred in the Republic of Vietnam between 02/28/61 and 05/07/75, or between 08/05/64 and 05/07/75 in all other cases, and was discharged or released therefrom with other than a dishonorable discharge; or, a person who was discharged or released from active duty for a service-connected disability if any part service-connected disability if any part of such active duty was performed in the Republic of Vietnam between 02/28/61 and 05/07/75 or between 08/05/64 and 05/07/75 in all other cases.
- OTHER VETERAN**: A person who served in an armed conflict for which a declaration of war was issued by Congress or an expedition for which a campaign badge has been awarded.

Questions regarding this survey may be directed to the Human Resources Department

Signature (optional)

Date