



**APPLICATION
FOR EMPLOYMENT
(Please Print)**

The South Bend Clinic, LLP is an equal opportunity employer. Applicants are considered for employment based on ability and experience necessary to perform the job without regard to race, color, religion, sex, age, disability, citizenship status, national origin, or any other basis prohibited by law, unless such basis constitutes a bona fide occupational qualification. The South Bend Clinic, LLP will comply with its legal obligations to provide reasonable accommodation to qualified individuals with disabilities.

It is also the policy of The South Bend Clinic, LLP to hire only United States citizens or individuals lawfully authorized to work in the United States, and to require all new employees to complete the designated employer's verification forms.

DO NOT WRITE IN THIS SPACE

APPLICANT SCREENING

- Check References
- Set Interview ___/___/___ :___ AM/PM
- + - closed _____

APPLICANT ACTION

- Recommended for Employment Yes No
- Hire Date ___/___/___ Employee # _____
- Location _____
- Department _____
- Position _____
- Status Exempt Non-Exempt FTE_____
- FT PT PRN Temp
- Hours Per Week _____ Hourly Wage \$ _____

DATE: _____ POSITION APPLYING FOR: _____

REFERRAL SOURCE: Walk-In Classified Ad Referred by Employee _____ SBC Web Site Other _____

NAME _____
Last First Middle

SSN (Optional): _____

ADDRESS _____
Street Address
City State Zip Code

EMAIL: _____

PHONE #: () _____
() Home
() Cell
Work

ARE YOU SEEKING: Full-time Part-time PRN Temporary **How many hours per week do you desire?** _____

WOULD YOU BE ABLE TO WORK: Saturdays Sundays Holidays Day Shift Evening Shift
 Overtime Float Position

DATE AVAILABLE FOR WORK: _____ SALARY REQUIREMENTS: _____ (If negotiable, please specify minimum)

ARE YOU A UNITED STATES CITIZEN OR LAWFULLY AUTHORIZED TO WORK IN THE UNITED STATES? Yes No

HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN A MINOR TRAFFIC VIOLATION? Yes No

IF YES, please state when, where and the final outcome

HAVE YOU EVER BEEN INTERVIEWED AT THE SOUTH BEND CLINIC OR ANY OF ITS FACILITIES? Yes No **If yes, when** _____

List position/dept. _____

HAVE YOU EVER BEEN EMPLOYED BY THE SOUTH BEND CLINIC OR ANY OF ITS FACILITIES? Yes No **If yes, when** _____

and where: Downtown (*specify department*) _____ Michiana Pediatrics Family Care Associates Granger Family Medicine

Business Office Ironwood Medical Group Skyway Primary Care SB Clinic at Granger SB Clinic at New Carlisle Other _____

LIST ANY RELATIVE(S) EMPLOYED AT ANY OF OUR LOCATIONS (*This information will be used only for job assignment*)

 Name Relationship Facility/Department Name Relationship Facility/Department

EMPLOYMENT HISTORY (List below **ALL** previous employers, **beginning with your present or most recent employer** regardless of whether or not a resume was submitted.)

COMPANY	FROM		TO		TITLES & DUTIES	LAST SALARY	SUPERVISOR	REASON FOR LEAVING
	MO	YR	MO	YR				
Name:								
Address:								
City: State: Zip:								
Phone:								
Name:								
Address:								
City: State: Zip:								
Phone:								
Name:								
Address:								
City: State: Zip:								
Phone:								
Name:								
Address:								
City: State: Zip:								
Phone:								
Name:								
Address:								
City: State: Zip:								
Phone:								

Phone: _____

DID YOU WORK UNDER ANY OTHER NAME FOR YOUR CURRENT OR PREVIOUS EMPLOYER(S)? Yes No

If **YES**, please list previous name: _____

MAY WE CONTACT YOUR PRESENT EMPLOYER? Yes No **IF NO, WHY NOT?** _____

RECORD OF EDUCATION					
SCHOOL	NAME AND ADDRESS	NUMBER OF YEARS ATTENDED	DID YOU GRADUATE?	LIST TYPE OF DEGREE, LICENSE, OR CERTIFICATION RECEIVED	LIST AREA OF STUDY
HIGH SCHOOL				N/A	N/A
COLLEGE/ NURSING					
SPECIALIZED TRAINING (Specify)					
OTHER					

PLEASE LIST 3 BUSINESS REFERENCES

Name	Association	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST 3 PERSONAL REFERENCES

Name	Association	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROFESSIONAL AND TECHNICAL INFORMATION (R.N., L.P.N, C.M.A., Technicians, other Professionals)

Are you licensed, certified or registered? Yes No If yes, state number of years you have been licensed, certified or registered _____ In what state? _____

License: Type: _____ Certification Number _____ Expiration Date _____

Registration: Type: _____ Certification Number _____ Expiration Date _____

Certification: Type: _____ Certification Number _____ Expiration Date _____

HAVE YOU EVER BEEN EXCLUDED, DEBARRED, SUSPENDED OR OTHERWISE DEEMED INELIGIBLE TO PARTICIPATE IN ANY FEDERAL PROGRAMS INCLUDING, FOR EXAMPLE, MEDICARE OR MEDICAID? Yes No

APPLICANT'S STATEMENT

(Please indicate that you have read and understand each paragraph of this Applicant's Statement by placing your initials beside each paragraph.)

Initials

- _____ I certify that this application was completed by me and that all entries and information in it are TRUE and COMPLETE to the best of my knowledge. In the event of employment, I understand that the discovery of false, misleading or omitted information in my application may result in my discharge.

- _____ I authorize investigation of all statements contained in this application as may be necessary in arriving at an employment decision. I understand that an investigation may be made and information may be obtained through interviews with personal references and past employers, through a criminal history check, and through review of federal agency lists of individuals ineligible to participate in federal programs. This inquiry may include information as to, among other things, my character, general reputation and personal conduct. I consent to this investigation and to the consideration of any statements of references, former employers or others that are given in response to the inquiry.

- _____ I hereby release all parties, including but not limited to The South Bend Clinic, LLP, personal references and previous employers, from liability for any injury or damage that may result from their furnishing information concerning me or any action The South Bend Clinic, LLP takes on the basis of such information.

- _____ I understand that, according to federal law, all individuals who are hired must, as a condition of employment, produce certain documentation to verify their identity and United States citizen status or, if aliens, their legal authorization to work in the United States. As a consequence, I understand that any offer of employment to me is contingent upon my ability to produce the required documentation within the time period required by law.

- _____ I understand that this application is not, and is not intended to be, a contract of employment and that any resulting employment is for no fixed period of time and is terminable at any time and for any reason by me or by The South Bend Clinic, LLP. I further understand that statements which may be contained in policies, practices, handbooks or other material do not create any guarantee of employment and that The South Bend Clinic, LLP has the right to modify, amend or terminate policies, practices, benefits plans or other programs within the limits and requirements imposed by law. I understand that no representative of The South Bend Clinic, LLP, other than an officer, has the authority to enter into any agreement for any specific period of time to make any agreement contrary to the foregoing and that any such agreement must be in writing to be binding.

- _____ I understand that any offer of employment will be conditioned upon a check for exclusion or debarment from any federally or state funded health care program, a check for convictions for health care fraud and abuse, a screening procedure for illegal drugs, and a behavioral and skills assessment which will occur before I begin work.

- _____ I understand that The South Bend Clinic, LLP, abides by the Service Standards as a way of providing medical care. I acknowledge that I have reviewed the Service Standards provided by The South Bend Clinic, LLP.

_____ Date

_____ Signature of Applicant

08/22/08

THIS APPLICATION WILL NOT BE CONSIDERED ACTIVE AFTER 90 DAYS
