



Employment Application

Last Name:	First Name:	M.I.:	
Address:	City:	State:	Zip:
Phone Number:	Email :		
<i>Please complete this application for employment as thoroughly as possible. The information you provide will be considered confidential. Your signature and the date it was signed is required. This is an official legal document.</i>			

Provider Plus, Inc. is a Equal Opportunity Employer

Applicants are considered for employment without regard to race, color, national origin, ancestry, religion, sex, pregnancy (including childbirth or related condition), physical or mental impairment, medical conditions associated with arrested cancer, marital status, or age, in any term, condition or privilege of employment to the extent required by law.

EMPLOYMENT / MILITARY EXPERIENCE

Please list your job history for the past ten years (or last four employers). Start with your present status and note any periods in which you were not employed. Include US military service. Show rank/rate at discharge (but not type of discharge). Please complete in full even if resume is attached.

1.) Current or Last Employer:			
Address: (Street, City, State, ZIP Code)			
Supervisor & Title:		Supervisor's Phone # & Extension:	
Dates of Employment (Month & Year)	Beginning Salary &/or Commission	Ending Salary &/or Commission	
From: To:	\$ /month	\$ /month	
Your title & summary of duties:			
List reasons for leaving:			May we contact this employer? yes no

2.) Previous Employer:			
Address: (Street, City, State, ZIP Code)			
Supervisor & Title:		Supervisor's Phone # & Extension:	
Dates of Employment (Month & Year)	Beginning Salary &/or Commission	Ending Salary &/or Commission	
From: To:	\$ /month	\$ /month	
Your title & summary of duties:			
List reasons for leaving:			May we contact this employer? yes no



JOB SPECIFICATION	
Position Desired:	Work location desired:
Pay/Salary Desired: _____ Year	per: _____ Hour _____ Week _____ Month
If your position requires you to drive, can you furnish a valid driver's license? _____ Yes _____ No	
If yes, Please provider your: License #: _____ State: _____	
The following conditions may be required at some point in a job assignment. If required, would you be willing to work:	
a.) Shift Work _____ Yes _____ No b.) Alternative work week, compressed work week, flextime _____ Yes _____ No	
c.) Work schedule other than Monday through Friday _____ Yes _____ No d.) Overtime Work _____ Yes _____ No	

REFERENCES	
List business, professional or academic references.	
Name:	Title:
Phone #:	Relationship:
Name:	Title:
Phone #:	Relationship:

SECURITY DATA (ILLINOIS RESIDENTS DO NOT ANSWER)
<p>Have you ever been convicted of a felony or misdemeanor? (Do not include any juvenile offenses, or military convictions, except by general court-martial.) _____ Yes _____ No A yes answer will not automatically disqualify you for employment. If the answer is yes, please furnish details of conviction, offense, location, date and sentence.</p> <p>_____</p> <p>_____</p>

<p><i>Provider Plus, Incorporated is a drug free work place. All prospective employees may be required to undergo and pass a drug screen for the use of illegal substances. Certain positions may require passing a complete physical examination concerning the person's ability to perform job-related functions prior to beginning work.</i></p> <p>Are you currently using any illegal or controlled substances, other than those prescribed to you by a physician? _____ Yes _____ No If the answer is yes, please furnish details.</p> <p>_____</p> <p>_____</p>

<p><i>My signature certifies that this application was completed by me and all information provided is true and complete to the best of my knowledge. I hereby authorize Provider Plus Incorporated to conduct a complete investigation of me, my former business relations and employment. Additionally, I authorize any business organization or any other person to give full information and records about me. I release Provider Plus Incorporated, its officers, associates and informants, and federal, state, and local law enforcement agencies from all liability arising from this investigation. I grant Provider Plus Incorporated the authority to allow legally constituted authorities to review all pertinent parts of my personnel file. I understand that any omission or misrepresentation herein may result in termination of employment. If employed, I understand that my employment with Provider Plus Incorporated is for an indefinite period of time. My employment may be terminated by me or the company at any time, with or without prior notice or cause.</i></p> <p>Signature of Applicant: _____ Date: _____</p>
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