 500 Independence Parkway, Suite 100

Chesapeake, VA 23320

757-547-9714

 Fax 757-547-0725

**Eastern Virginia Ear, Nose and Throat Specialists**

# Employment Application

**Applicant’s Name**: ­

This practice does not discriminate against applicants on the basis of race, sex, color, religion, national origin, age, disability, or veteran status. We are an Equal Employment Opportunity Employer.

Date:

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:

City: Zip: Phone:

Cell Phone: email:

Emergency Contact: Relationship:

Phone: Cell Phone:

Name you go by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position applying for: Days available:

Salary desired: How did you hear about the position?

Have you ever worked here before? **YES / NO**  When?

Why did you leave?

Have you ever served in the military? **YES / NO** Branch:

Dates: Special Training:

Are you currently in the Reserves? **YES / NO** Branch:

Are you licensed to drive a vehicle? **YES / NO**

If hired can you provide proof that you are 18 years old or older? **YES / NO**

If hired can you provide proof that you are eligible to work in the United States? **YES / NO**

**EDUCATION**

# SCHOOL MAJOR AREA STUDIED YR COMPLETED DEGREE

Name of High School

Name of VoTech School

Name of College

Name of Post College

**Professional Registration, License Information** (Must be completed if required by the position applied for)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Registration # | Renewal # | Date Issued | Date Expires | Type |
| State |  |  |  |  |  |
| National |  |  |  |  |  |
|  |  |  |  |  |  |

Has your professional nursing license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location? **YES / NO** When and Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other Technical Skills or Certifications, etc.

**WORK HISTORY**

**Please list your last four (4) positions:**

Company Name:

Address:

Position: Dates:

Supervisor: Pay Rate:

Phone: Reason for leaving:

May we contact for Reference? **YES / NO**

Company Name:

Address:

Position: Dates:

Supervisor: Pay Rate:

Phone: Reason for leaving:

May we contact for Reference? **YES / NO**

Company Name:

Address:

Position: Dates:

Supervisor: Pay Rate:

Phone: Reason for leaving:

May we contact for Reference? **YES / NO**

Company Name*:*

Address:

Position: Dates:

Supervisor: Pay Rate:

Phone: Reason for leaving:

May we contact for Reference? **YES / NO**

**List three professional references (**Not family and preferably two managers)**:**

**Professional:**

Name: Title:

Company: Phone:

Address:

Position in relationship to your employment:

Name: Title:

Company: Phone:

Address:

Position in relationship to your employment:

Name: Title:

Company: Phone:

Address:

Position in relationship to your employment:

Have you ever been convicted or pled guilty to a crime other than a traffic citation? **YES / NO** Explain:

**APPLICANT’S STATEMENT**

It is the goal of Eastern Virginia Ear Nose & Throat Specialists (EVENTS) to employ the qualified individual who best matches the requirements for the position to be filled. I certify that the statements herein are made truthfully without evasion and agree that the statements may be investigated and if found false may subject me to disqualification for employment or be sufficient reason for my dismissal. EVENTS reserves the right to make any investigation into my previous employment history, financial, credit or public records, including criminal background through investigative or credit agencies or bureaus of EVENTS choice. I understand that by authorizing this investigation, it is not a promise of employment. I authorize all schools which I attended and all previous employers to furnish EVENTS with my record, reason for leaving and all information they may have concerning me and hereby release them and EVENTS from all liability for any damage whatsoever arising there from.

I have read and agree to the above statement. YES / NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Revised 6/26/17 (LO/BG)**

Effective June 2015

Copies of the following documentation must accompany the completed Employment Application:

* Driver’s License
* Social Security Card OR Passport
* Clinical License (if applicable)
* Documentation of Tetanus (Clinical Staff only)
* Documentation of Hepatitis B Vaccine (Clinical

Staff only)

* Documentation of CPR Certification (Clinical Staff only)



|  |  |
| --- | --- |
| Jeffrey P. Powell, M.D., D.D.S., F.A.C.S. |  Practice Manager – Lisa Okerlund |
| Alan S. Keyes, M.D., F.A.C.S |  Audiology - Paula A. Abraham, Au.D., CCC-A |
|  Kimberly Pasquale, M.D., F.A.C.S |  Stephanie R. Howard, M.A., CCC-A |
| Richard F. Debo, M.D., F.A.C.S. |  Stephanie M. Collins, Au.D., CCC-A |
| Ryan P. Hester, M.D. |  Michael W. LeMay, Au.D., CCC-A |
| David W. Leonard, M.D., F.A.C.S. |  Kaitlyn Derrenberger, Au.D., CCC-A |
| Kiim Scott, F.N.P., A.E.-C, CORLN |  Bookkeeper/HR Specialist - Betsey Granger |
| Alexis L. Buettner, MPA, PA-C |  |
|  |  |

**Background Check Authorization**

Print Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

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

 Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The position for which I am being considered requires me to consent to a criminal background check as a condition of employment and/or internship. I understand that by authorizing a background check, it is not a promise of employment.

 I hereby authorize Eastern Virginia Ear Nose & Throat Specialists to conduct a comprehensive review of my background for employment and/or volunteer purposes. I understand that the scope of the investigative report may include, but is not limited to the following areas: verification of social security card; civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, and any other public records.

This information given by me is true and complete in all respects, and I agree that if the information is found to be false, misleading, or unsatisfactory in any respect(in the exclusive judgment of Eastern Virginia Ear, Nose & Throat Specialists) that I will be disqualified from consideration for employment.

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



CHESAPEAKE • 500 Independence Pkwy., Suite 100, Chesapeake, VA • 23320 • 757-547-9714, Fax 757-547-0725 VIRGINIA BEACH • 361 Southport Circle, Suite 100, Virginia Beach, VA 23452 • 757-464-1500, Fax 757-460-1362

SUFFOLK • 1037 Champions Way, Suite 100, Suffolk, VA 23321 • 757-465-3106, Fax 757-465-8131