



ATC Healthcare Services, Inc. is an Equal Employment Opportunity employer and does not discriminate because of race, color, religion, national origin, sex, age, disability, or any other protected characteristic as established by federal, state or local laws.

DATE

# HEALTHCARE ASSOCIATE EMPLOYMENT APPLICATION

POSITION APPLIED FOR: \_\_\_\_\_ DATE AVAILABLE: \_\_\_\_\_

PLEASE PRINT

<b>PERSONAL</b>		SOCIAL SECURITY NO.
NAME (LAST, FIRST, MIDDLE)		HOME PHONE NO. ( )
STREET ADDRESS		CELL PHONE NO. ( )
CITY, STATE, ZIP		PAGER NO. ( )
PLEASE LIST OTHER NAME(S) BY WHICH YOU ARE KNOWN NOW OR IN THE PAST:		E-MAIL ADDRESS
IF NECESSARY, THE BEST TIME TO CALL ME AT HOME IS:		

**GENERAL DATA**

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES?  YES  NO

DO YOU HAVE A RELIABLE MEANS OF TRANSPORTATION TO JOB ASSIGNMENTS?  YES  NO

HOW DID YOU LEARN ABOUT ATC?

WALK IN  AD (PUBLICATION): \_\_\_\_\_  REFERRED BY: \_\_\_\_\_  ATC REPRESENTATIVE

HAVE YOU EVER REGISTERED WITH OR BEEN EMPLOYED BY ATC BEFORE?  YES  NO

IF SO, PLEASE GIVE DATES AND ATC OFFICE: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A CRIME? \*  YES  NO IF YES, HOW MANY TIMES? \_\_\_\_\_

PROVIDE DATE(S) AND DETAILS (USE ADDITIONAL SHEET IF NECESSARY) \_\_\_\_\_

DO YOU HAVE ANY CURRENT INDICTMENTS AND/OR PENDING CRIMINAL CHARGES AGAINST YOU?  YES  NO

IF YES, PROVIDE DATE(S) AND DETAILS (USE ADDITIONAL SHEET IF NECESSARY) \_\_\_\_\_

\* A PRIOR CONVICTION WILL NOT NECESSARILY BE A BAR TO EMPLOYMENT.

**TO BE COMPLETED BY PATIENT CARE APPLICANTS**

HAS A LICENSE/CERTIFICATION EVER BEEN ISSUED IN ANOTHER STATE?  YES  NO

IF YES, PLEASE GIVE DETAILS \_\_\_\_\_

DO YOU HAVE A CURRENT, VALID LICENSE/CERTIFICATION?  YES  NO

LICENSE/CERT. TYPE \_\_\_\_\_ STATE \_\_\_\_\_ LICENSE NO. \_\_\_\_\_ EXP. DATE \_\_\_\_\_

LICENSE/CERT. TYPE \_\_\_\_\_ STATE \_\_\_\_\_ LICENSE NO. \_\_\_\_\_ EXP. DATE \_\_\_\_\_

SPECIALTY/OTHER \_\_\_\_\_ STATE \_\_\_\_\_ LICENSE NO. \_\_\_\_\_ EXP. DATE \_\_\_\_\_

CPR \_\_\_\_\_ EXP. DATE \_\_\_\_\_

ACLS \_\_\_\_\_ EXP. DATE \_\_\_\_\_

HAS YOUR PROFESSIONAL LICENSE, CERTIFICATE OR REGISTRATION EVER BEEN SUBJECT TO DISCIPLINARY ACTION BY ANY STATE BOARD OR BODY, SUCH AS BY REPRIMAND, SUSPENSION, REVOCATION, CONSENT ORDER, VOLUNTARY SURRENDER OR FINES?  YES\*  NO

ARE YOU CURRENTLY WORKING UNDER A CONSENT ORDER OR WITH A RESTRICTED LICENSE FROM ANY STATE LICENSING BODY OR BOARD?

YES\*  NO

ARE YOU AWARE OF ANY PENDING COMPLAINTS OR INVESTIGATIONS AGAINST YOUR PROFESSIONAL LICENSE, CERTIFICATE OR REGISTRATION IN ANY STATE TO THE BEST OF YOUR KNOWLEDGE?  YES\*  NO

\* IF YES, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.

**DATA TO BE COMPLETED BY PATIENT CARE APPLICANTS (CONT.)**

DO YOU HAVE ANY RESTRICTIONS WHICH WOULD INTERFERE WITH YOUR ABILITY TO PERFORM THE ESSENTIAL DUTIES OF THE POSITION FOR WHICH YOU HAVE APPLIED?     YES     NO    EXPLAIN: \_\_\_\_\_

DO YOU HAVE PROFESSIONAL LIABILITY INSURANCE?     YES     NO

IF YES, GIVE CARRIER NAME: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_ EXP. DATE \_\_\_\_\_

**TO BE COMPLETED BY HEALTHCARE ADMINISTRATIVE APPLICANTS**

DO YOU HAVE TYPING SKILLS?     YES     NO    \_\_\_\_\_ WPM

DO YOU HAVE WORD PROCESSING SKILLS?     YES     NO    \_\_\_\_\_ WPM

DO YOU HAVE COMPUTER SKILLS?     YES     NO    TYPE OF SOFTWARE \_\_\_\_\_

HAVE YOU COMPLETED A COURSE IN MEDICAL TERMINOLOGY?     YES     NO    DATE \_\_\_\_\_

HAVE YOU COMPLETED A COURSE IN MEDICAL BILLING/CODING?     YES     NO    DATE \_\_\_\_\_

SUMMARIZE ANY SPECIAL TRAINING, SKILLS, LICENSES AND/OR CERTIFICATES THAT MAY QUALIFY YOU AS BEING ABLE TO PERFORM JOB-RELATED FUNCTIONS IN THE POSITION FOR WHICH YOU ARE APPLYING \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WORK HISTORY**

APPLICATIONS WILL NOT BE CONSIDERED UNLESS ALL INFORMATION IS COMPLETE - EVEN IF A RESUME IS PRESENTED.

**PRESENT POSITION**

FROM: MONTH    YEAR		TO: MONTH    YEAR		EMPLOYER	TELEPHONE NUMBER (    )
				STREET ADDRESS, CITY, STATE, ZIP	
POSITION		HOURLY PAY RATE \$	SUPERVISOR'S NAME AND TITLE		MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE DUTIES AND SPECIALTY AREAS				REASON FOR LEAVING:	
# OF HOSPITAL BEDS (IF APPLICABLE)		ARE YOUR EMPLOYMENT RECORDS LISTED UNDER ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHAT NAME?			

**PREVIOUS POSITION**

FROM: MONTH    YEAR		TO: MONTH    YEAR		EMPLOYER	TELEPHONE NUMBER (    )
				STREET ADDRESS, CITY, STATE, ZIP	
POSITION		HOURLY PAY RATE \$	SUPERVISOR'S NAME AND TITLE		MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE DUTIES AND SPECIALTY AREAS				REASON FOR LEAVING:	
# OF HOSPITAL BEDS (IF APPLICABLE)		ARE YOUR EMPLOYMENT RECORDS LISTED UNDER ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHAT NAME?			

## PREVIOUS POSITION

FROM: MONTH YEAR		TO: MONTH YEAR		EMPLOYER	TELEPHONE NUMBER ( )
STREET ADDRESS, CITY, STATE, ZIP					
POSITION		HOURLY PAY RATE \$	SUPERVISOR'S NAME AND TITLE		MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE DUTIES AND SPECIALTY AREAS				REASON FOR LEAVING:	
# OF HOSPITAL BEDS (IF APPLICABLE)		ARE YOUR EMPLOYMENT RECORDS LISTED UNDER ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHAT NAME?			

LIST OTHER EMPLOYERS AND DATES OF EMPLOYMENT. ATTACH A RESUME IF AVAILABLE.

## PERSONAL REFERENCES

LIST NAME AND TELEPHONE NUMBER OF THREE BUSINESS/WORK REFERENCES WHO ARE **NOT** RELATED TO YOU AND ARE **NOT** PREVIOUS SUPERVISORS. IF NOT APPLICABLE, LIST THREE SCHOOL OR PERSONAL REFERENCES WHO ARE NOT RELATED TO YOU.

NAME	TELEPHONE	NUMBER OF YEARS KNOWN
	( )	
	( )	
	( )	

## EDUCATION AND TRAINING

CIRCLE HIGHEST GRADE COMPLETED	COLLEGE	POST GRADUATE	MAJOR	NO. OF YEARS COMPLETED	DEGREE(S) OBTAINED									
						8	9	10	11	12	GED	1	2	3
HIGH SCHOOL	ADDRESS													
VOCATIONAL/TECHNICAL	ADDRESS													
HOSPITAL OR NURSING SCHOOL	ADDRESS													
COLLEGE/UNIVERSITY	ADDRESS													
POST GRADUATE	ADDRESS													

OTHER EDUCATION OR SPECIAL TRAINING (INCLUDE MILITARY)

## ACKNOWLEDGMENT AND AUTHORIZATION

I represent that the information provided in this employment application (and accompanying documents, if any) is true and complete. I understand that any false information or significant omissions may disqualify me from any further consideration for employment and may be justification for dismissal from employment if discovered at a later date. I agree to immediately notify ATC Healthcare Services, Inc. if I should be convicted of any crime while my job application is pending.

I authorize investigation of all statements contained in this application and authorize any individual or entity to provide information and opinion to ATC as part of the investigation. I authorize ATC to disclose information contained in this application along with any information about me obtained through investigations or during the course of the interview process. I release ATC Healthcare Services, Inc. and any individual, or entity providing information to ATC, from any legal liability for any damages from the disclosure of this information.

I understand that if accused of wrongdoing while employed, I may be subject to probe by an outside agency.

I understand and agree that, if I am hired, my employment is "at-will" which means that it is for no definite period of time and may be terminated by me or ATC at any time for any reason.

I understand that if I am hired, ATC does not guarantee any specific number of hours or shifts and I may or may not be assigned as determined by ATC. I understand and agree that I will not accept employment by any ATC client where I have been assigned by ATC for a period of six (6) months following termination of my employment with ATC.

I understand that if I am hired, a client may decide not to utilize my services at any time and will inform ATC if this occurs. That decision is made solely by the client. I understand that disclosure of the reason(s) for any such decision is at the sole discretion of the client and that I am not privy to that information. I understand and acknowledge that if this occurs, I may, or may not be assigned to other clients. In the event I have any concerns regarding my assignment to a client, I will immediately bring my concerns to ATC's attention.

I agree, if I am hired by ATC, to keep my credentials and JCAHO and OSHA inservice requirements current, and to abide by the policies, procedures and supervision of the client to which I am assigned and those of ATC Healthcare Services, Inc.

### CONSUMER NOTIFICATION FOR ATC HEALTHCARE SERVICES, INC.

This is to inform you that a consumer report or an investigative consumer report may be obtained from a consumer reporting agency for the purpose of evaluating you for employment, assignment, promotion, reassignment or retention as an employee.

This report may contain information bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living from public record sources or through personal interviews with your neighbors, friends or associates. You may also have the right to request additional disclosures regarding the nature and scope of the investigation.

Acknowledged and agreed:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

### (TO BE COMPLETED BY ATC REPRESENTATIVE ONLY)

On what date will employee be available for assignment?						
Hours Associate available for assignment:	7a - 3p	3p - 11p	11p - 7a	7a - 7p	7p - 7a	Other _____
Days available for assignment:	SAT	SUN	MON	TUE	WED	THUR FRI
Any special requests:						
Assignment preferences				Comments/Area Preference		
Contracts - Local	Yes	No				
Local Travel	Yes	No				
Specialty Areas:	1st Choice:	2nd Choice:	3rd Choice:			

ATC Representative: \_\_\_\_\_ Date: \_\_\_\_\_