



This employment application is only active for 30 days. After this time period a separate employment application must be submitted in order to be considered for employment.

Please Print Clearly

APPLICANT INFORMATION			
Name: Last	First	Middle	Today's Date
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Email	Best way to contact <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email	May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you legally eligible to be employed in the U. S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Proof of US Citizenship or immigrant status will be required if hired</i>	Available Start Date	
List any other names you have worked under:		List any friends or relatives employed by this company:	

POSITION		
What position(s) are you applying for? <input type="checkbox"/> Sales/Management <input type="checkbox"/> Counseling <input type="checkbox"/> RN, LPN, CMA, MA <input type="checkbox"/> Other	Employment Status Desired <input type="checkbox"/> Full Time <input type="checkbox"/> Temporary <input type="checkbox"/> Part Time <input type="checkbox"/> On Call	Salary Desired
How did you find out about this job? <input type="checkbox"/> Advertisement <input type="checkbox"/> Current Employee <input type="checkbox"/> Website <input type="checkbox"/> Staffing Company <input type="checkbox"/> Referral; who: <input type="checkbox"/> Other, please explain:		
Please check the skills for which you have been trained or have experience? <input type="checkbox"/> Filing <input type="checkbox"/> Receptionist <input type="checkbox"/> Appointments/Scheduling <input type="checkbox"/> Accounting <input type="checkbox"/> Sales		
Technical Skills <input type="checkbox"/> Calculator <input type="checkbox"/> Computer <input type="checkbox"/> Credit Card Machine <input type="checkbox"/> Fax		
Medical Skills/Knowledge (RN, LPN, CMA, MA applicants only) <input type="checkbox"/> Blood Pressure Cuffs <input type="checkbox"/> Centrifuge <input type="checkbox"/> Scale <input type="checkbox"/> Medical Terms <input type="checkbox"/> Blood Draw <input type="checkbox"/> B12 Injections		
Have you ever worked for this organization before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	If hired, how long do you plan to work for MEDICAL WEIGHT LOSS CLINIC?	

EMPLOYMENT DATA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If hired, do you have a reliable means of transportation to get to work?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If hired, will you be available to work overtime?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If hired, are you willing to work holidays?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If hired, are you willing to travel if the position requires it?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently employed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been discharged or asked to resign from a position? If yes, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on layoff and subject to recall? If yes, explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been convicted of a felony? <i>(A yes answer does not automatically disqualify your application)</i> If yes, please explain:

EDUCATION		
Please circle the highest level/year completed		
High School	College	College
9 10 11 12 GED	Associates Bachelors Masters Other	Associates Bachelors Masters Other
Name of School	Name of School	Name of School
Location of School	Location of School	Location of School
Are you enrolled in a co-op program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Degree and Major	Degree and Major

MILITARY SERVICE
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list dates of service: From: _____ To: _____
List any special skills or training:

EMPLOYMENT HISTORY		
<i>List all employments for the past four years, starting with the most recent position. (Attach additional sheets if necessary)</i>		
Employer Name	Phone	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later
Employer Address		
Date of Hire / /	Starting Salary	Supervisor Name
Employed Until / /	Ending Salary	Supervisor
Job Title	Reason for Leaving	
Duties and Responsibilities		
Employer Name	Phone	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later
Employer Address		
Date of Hire / /	Starting Salary	Supervisor Name
Employed Until / /	Ending Salary	Supervisor
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Employed Until / /	Ending Salary	Supervisor
Job Title	Reason for Leaving	
Duties and Responsibilities		

REFERENCES		
<i>Please provide three non-relative references.</i>		
Reference Name	Relationship to Applicant	Phone #
Reference Title/Position	Number of years known	
Reference Name	Relationship to Applicant	Phone #
Reference Title/Position	Number of years known	
Reference Name	Relationship to Applicant	Phone #
Reference Title/Position	Number of years known	

CERTIFICATION, AUTHORIZATIONS AND AGREEMENTS	
<i>Please read the following statements carefully and indicate your agreement by checking Yes or No in the left column.</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	CERTIFICATION: I certify that the facts set forth in this application are true and complete. I agree that any false, misleading, or incomplete information in this application, or given during an interview or other employment forms I may subsequently complete, may result in my disqualification from employment with MEDICAL WEIGHT LOSS CLINIC or in my dismissal from employment, if hired, no matter when the falsification or omission is discovered.
<input type="checkbox"/> Yes <input type="checkbox"/> No	FORMER EMPLOYERS AND BACKGROUND INFORMATION: I authorize MEDICAL WEIGHT LOSS CLINIC to contact the appropriate entities to investigate the facts submitted in this application, including, but not limited to, criminal background organizations, all my former and current employers, schools, and references. I authorize such entities to disclose and make copies available to MEDICAL WEIGHT LOSS CLINIC all requested information, whether or not it is included in my personnel or other record, including but not limited to, any information concerning any unprofessional conduct by me. I release MEDICAL WEIGHT LOSS CLINIC and all of my former and current employers, educational institutions, and the other references I have provided, from any and all liability and damages for releasing or using information concerning me and my work, academic, and/or other experience.
<input type="checkbox"/> Yes <input type="checkbox"/> No	DRUG TESTING: I understand that I may be asked to undergo such medical examinations and drug tests as MEDICAL WEIGHT LOSS CLINIC may require, and release them from any liability in doing so. I also understand that any offer of employment I may receive may be contingent upon my satisfactory completion of such medical exam or drug test.
<input type="checkbox"/> Yes <input type="checkbox"/> No	DISABILITY: I understand that Michigan law requires that a person with a disability or handicap requiring accommodation to perform the essential duties of the job must notify the employer in writing within 182 days of the date that the need for accommodation is known or should have been known.
<input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYMENT-AT-WILL: I understand that nothing in this application or the above Certification, Authorizations and Agreements constitutes an employment contract. If I am hired, it will be "employment-at-will" and employment can terminate at the will of either party, with or without cause.

Applicant Signature

Date