MEDICAL EMPLOYMENT DIRECTORY
APPLICATION FOR EMPLOYMENT

TODAY'S DATE: _____

DATE AVAILABLE: _____

PRIOR INTERVIEW DATE : _____

Staff Soft ____ Resume ____ References ____

CBG ____ DS ____

E-MAIL ADDRESS: _____

LAST:

FIRST:

FILED:

Medical Employment Directory is an Equal Opportunity Employer. We consider all applicants without regard to race, color, creed, religion, sex, national origin, age, marital or veteran's status, disabilities, and any other legally protected status. It is our policy to abide by all Federal, State, and local laws concerning discrimination in employment. No question in this application is intended to elicit information in violation of any such laws nor will any information obtained in response to any question be used in violation of such law.

☐ FULL TIME ☐ PART TIME ☐ TEMPORARY ☐ TEMP/PERM

Social Security Number _____

POSITION(S) APPLYING FOR:

1	2	3
FIRST	MIDDLE	LAST
ADDRESS		
CITY	STATE	ZIP
WORK PHONE	HOME PHONE	PAGER OR CELLULAR

EMERGENCY CONTACTS

NAME	PHONE	NAME	PHONE

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO

WHERE?

TITLE CURRENT EARNINGS DESIRED SALARY

IN WHAT AREAS OF THE CITY DO YOU PREFER TO WORK?

HOW DID YOU HEAR ABOUT MEDICAL EMPLOYMENT DIRECTORY?

HAVE YOU PREVIOUSLY APPLIED FOR WORK THROUGH M.E.D.? ☐ YES ☑ NO

DO YOU HAVE ANY TRANSPORTATION PROBLEMS? ☐ Yes ☐ No If yes, please explain:

ARE YOU WILLING TO DO "STAT" CALLS? ☐ YES ☐ NO

ARE YOU WILLING TO RELOCATE? ☐ YES ☐ NO

ARE YOU AVAILABLE TO WORK OVERTIME? ☐ YES ☐ NO

In 25 words or less, please describe yourself.

photograph goes here

LIST YOUR 4 MOST RECENT EMPLOYERS: (starting with most current)

COMPANY:

SUPERVISOR'S NAME: PHONE #:

YOUR JOB TITLE/DESCRIPTION OF DUTIES:

DATE OF EMPLOYMENT: From: To:

PART TIME ☐ FULL TIME ☐ EARNINGS: START: LAST:

REASON FOR LEAVING:

COMPANY:

SUPERVISOR'S NAME: PHONE #:

YOUR JOB TITLE/DESCRIPTION OF DUTIES:

DATE OF EMPLOYMENT: From: To:

PART TIME ☐ FULL TIME ☐ EARNINGS: START: LAST:

REASON FOR LEAVING:

COMPANY:

SUPERVISOR'S NAME PHONE #:

YOUR JOB TITLE/DESCRIPTION OF DUTIES:

DATE OF EMPLOYMENT: From: To:

PART TIME ☐ FULL TIME ☐ EARNINGS: START: LAST:

REASON FOR LEAVING:

COMPANY:

SUPERVISOR'S NAME: PHONE #:

YOUR JOB TITLE/DESCRIPTION OF DUTIES:

DATE OF EMPLOYMENT: From: To:

PART TIME ☐ FULL TIME ☐ EARNINGS: START: LAST:

REASON FOR LEAVING:

May we contact your former employers? ☐ Yes ☐ No

Does your present employer know you are looking for other employment? ☐ Yes ☐ No

May we call you at work regarding possible interviews? (We are very discreet.) ☐ Yes ☐ No

Have you ever been convicted of any felony or misdemeanor? ☐ Yes ☐ No
If yes, please explain and provide date and type of conviction

Have you ever been convicted of any traffic offense, which resulted in a felony and/or suspension, and/or revocation of your driver's license? ☐ Yes ☐ No
If yes, please explain and provide date and type of conviction

Have you ever been convicted for driving while intoxicated? ☐ Yes ☐ No

Are you currently using illegal drugs? ☐ Yes ☐ No

Are you willing to submit to pre-employment and/or random drug testing? ☐ Yes ☐ No

EDUCATION

	SCHOOL NAMES & LOCATION	COURSE OF STUDY	# YRS.	DID YOU GRADUATE	DIPLOMA
HIGH SCHOOL					
COLLEGE / UNIVERSITY					
COLLEGE / UNIVERSITY					
VOCATIONAL					
ADDITIONAL EDUCATION					

Can you verify your legal rights to work in the U.S. by providing a birth certificate, proof of U.S. citizenship or by some other means?
(Proof of U.S. citizenship or immigration status is required upon employment.) ☐ Yes ☐ No

Please list any languages you can read, write or speak.

BUSINESS REFERENCES ONLY - (Managers or Supervisors you worked for)

	NAME	TITLE	BUSINESS	TELEPHONE
1				
2				
3				
4				
5				

Please indicate any previous name(s) worked under

PLEASE READ THIS INFORMATION AND SIGN YOUR NAME BELOW.

I certify that, to the best of my knowledge and belief, the answers given by me to the questions and statements made by me are correct and complete. I understand that misrepresentation of omission of facts in this application may result in my discharge.

I authorize Medical Employment Directory to communicate with the employers I designate, school officials and persons names as referencing concerning my skills, character and responsibility. I authorize Medical Employment Directory to check employment references, criminal records and credit references. I agree to allow Medical Employment Directory to take my photograph for internal identification only. I authorize any individual and any entity to release information concerning me to Medical Employment Directory. I release any individual and any entity from any claims, damages or liability arising from the disclosure of information to Medical Employment Directory.

I authorize Medical Employment Directory to discuss my employment application, resume, and job abilities with any actual or potential employers. I release Medical Employment Directory and its' agents, officers, and employees from any liability arising from the disclosure of this information.

I acknowledge that the first 90 days of employment is a probationary time for me and the employer, and I understand that an employer may terminate my employment with or without fault on my part during the probationary period or any time thereafter; and that my employment is employment-at-will and is not governed by any expresses or implied contract.

I understand that my failure to provide proof of licensure may preclude Medical Employment Directory from placing me.

APPLICANT'S SIGNATURE (Please create a new digital ID) DATE

PLACEMENT INFORMATION

CLIENT	JOB	START DATE	STARTING SALARY	FEE

CLINICAL QUALIFICATIONS

(please check or answer appropriately)

NAME:

TITLE/DEGREE: Clinical Years of Experience:

Please list any certificates and/or licenses that you possess, including numbers:

Please give your license to our receptionist for copying.

What state(s) are you currently licensed in?

Has your license ever been revoked or suspended? ☐ Yes ☐ No

Is your licensing being investigated or has it been in the past? ☐ Yes ☐ No

Are you currently certified in the following areas? ☐ Yes ☐ No

	DATE:		DATE:
☐ OSHA Training?		☐ CPR?	
☐ Medical Terminology?		☐ BLS?	
☐ ACLS?			

SKILLS:

INJECTIONS ☐ IM ☐ SubQ ☐ Allergy Testing

IV ADMINISTRATION ☐ YES ☐ NO DATE CERTIFIED:

CHEMOTHERAPY ADMINISTRATION ☐ YES ☐ NO DATE CERTIFIED:

PULMONARY FUNCTION TESTS ☐ YES ☐ NO

VENIPUNCTURE ☐ YES ☐ NO NUMBER PER DAY?

BLOOD PRESSURE ☐ YES ☐ NO

CARDIAC SKILLS:

☐ EKG'S ☐ Holter Monitor ☐ Holter Monitoring Scanning ☐ Treadmill ☐ Arrhythmia Interpretation ☐ ECHO

Describe tests you perform:

ORTHOPEDIC EXP.:

LABORATORY: ☐ MLT ☐ MT ☐ NON-DEGREED TECH

CERTIFIED BY ASCP: ☐ YES ☐ NO ☐ DATE:

MISCELLANEOUS:

TESTS:

☐ URINALYSIS ☐ DIPSTICKS ☐ MICRO UA

☐ BLOOD CHEMISTRIES ☐ DRUG SCREEN ☐ HIV

SPECIALIZED EQUIPMENT:

RESEARCH EXPERIENCE:

OTHER:

RADIOLOGY: ☐ ARRT ☐ OTHER

SKILLS: ☐ CHEST ☐ EXTREMITIES ☐ MAMMOGRAM

☐ ULTRASOUND ☐ NMT ☐ CT

SPECIAL PROCEDURES:

What X-ray equipment have you used?

OTHER:

OPHTHALMOLOGY: ☐ COA ☐ COT ☐ NON-CERTIFIED

Refractions: ☐ AUTO ☐ MANUAL

LIST ALL OPHTHALMOLOGY SKILLS YOU PERFORM:

BUSINESS QUALIFICATIONS

(please check or answer appropriately)

NAME:

MEDICAL SPECIALTIES: (i.e. Orthopedic, Internal Medicine):

OFFICE MACHINE/SPECIALIZED EQUIPMENT:

COMPUTER: ☐ MS Word ☐ Excel ☐ WP ☐ Medical Software:

SCHEDULING: ☐ Computer or ☐ Manual ☐ of Doctors:

SWITCHBOARD/TELEPHONE: Number of lines System

MEDICAL RECORD FILING: ☐ Alpha ☐ Numeric ☐ Terminal Digit ☐ Other

TYPING: WPM Last Test Date: _____

TRANSCRIPTION: ☐ Yes ☐ No Years of Experience: ☐ Equipment:

FRONT DESK:

- ☐ COLLECT CO-PAYS
- ☐ VERIFY INSURANCE COVERAGE
- ☐ PREPARE CHARTS
- ☐ CALL PATIENTS TO CONFIRM APPTS
- ☐ DATA ENTRY OF INFO
- ☐ CHECK PATIENTS OUT
- ☐ HMO/PPO EXPERIENCE
- ☐ REFERRAL EXPERIENCE

INSURANCE CLAIM FILING: Years of experience:

EXPERIENCE:

☐ MEDICAL OFFICE ☐ INSURANCE COMPANY ☐ HOME HEALTH ☐ DME
☐ HOSPITAL ☐ LONG TERM CARE ☐ HOME INFUSION ☐

CLAIMS EXPERIENCE:

- ☐ MEDICARE PART A
- ☐ BLUE SHIELD
- ☐ UB92
- ☐ COMMERCIAL
- ☐ MEDICARE PART B
- ☐ MEDICAID
- ☐ HCFA
- ☐ 3RD PARTY
- ☐ HMO'S/PPO'S
- ☐ ELECTRONIC CLAIMS SUBMISSION
- ☐ WORKER'S COMP
- ☐ DISABILITY

- ☐ ICD-9 CODING
- ☐ REFILE DENIED/UNPAID INSURANCE CLAIMS
- ☐ CPT CODING
- ☐ A/R FOLLOW-UP/MANAGEMENT
- ☐ PROCESS REFUNDS
- ☐ COLLECTION CALLS TO PATIENTS
- ☐ VERIFY CLAIMS
- ☐ 3RD PARTY INSURANCE CLAIM FOLLOW-UP
- ☐ DAILY RECONCILIATION

ACCOUNTING:

- ☐ PAYROLL
- ☐ MONTH-END
- ☐ QUARTERLY
- ☐ ACCOUNTS PAYABLE
- ☐ TAXES

DATA ENTRY: # OF KEYSTROKES Last test date: _____

- ☐ POST CHARGES
- ☐ POST PAYMENTS
- ☐ POST ADJUSTMENTS
- ☐ DENIALS
- ☐ LINE ITEM POSTING
- ☐ EOB
- ☐ PATIENT DEMOGRAPHIC
- ☐ OTHER

MANAGEMENT: Number of People Managed: Practice Size: Hospital Size:

Years of Experience:

Have you hired/terminated employees? Management course:

Policy Manual: Seminars:

Special Projects:

Accomplishments:

Misc.

OSHA TRAINING? ☐ Yes ☐ No Date Certified:

MEDICAL TERMINOLOGY? ☐ Yes ☐ No Date Certified: