HEALTHCARE RECRUITERS
535 Willowbrook Office Park, Fairport, NY, 14450
Phone: (585) 586-0790 Fax: (585) 586-0989 Toll Free: 1-800-278-1463
E-mail: medjobs@medscribe.com Website: www.medscribe.com

Name:_____
(Last) (First) (Middle)

Have you worked under another name?_____ If so, Please list:_____

Address:_____
(Street) (City) (State) (Zip)

Phone Number: (_____)_____ Email:_____

Position applied for (please reference job number):_____ Are you currently employed?:_____

Hours per week sought:_____ Salary desired:_____ Are you able to temp?_____ Are you over the age of 18?_____

Are you a US citizen?_____Days and Hours available:_____ Date available to start:_____

ALL LICENSED PROFESSIONALS MUST COMPLTE OR YOUR APPLICATION WILL NOT BE CONSIDERED
Professional Registration Number: (If licensed) _____ Expires: _____
Has your license to practice in any jurisdiction ever been denied, terminated, limited, revoked, suspended, or voluntarily/involuntarily subject to probationary terms, or is there a pending action or challenge to do so?_____ If yes, explain: _____
_____
Have you ever been asked to resign or face termination? _____If yes, explain: _____
_____

Geographic location(s) in which you are willing to acccept a position:_____

Have you ever been convicted of a crime?_____ If yes, please list (include dates) and explain:
_____
_____

Criminal convictions are not necessarily a bar to employment. We evaluate the job-relatedness of the conviction, the nature and gravity of the criminal offense or conduct, the nature of the job (including where it is performed, how much supervision and interaction with others the employee will have and how much time has passed since the offense or sentence.

Education:

High School	Address	Diploma Received
College/Business School	Address	Diploma Received

Personal References: (no relatives, who have known you for at least one year)

Name	Phone	Occupation
1.		
2.		
3.		

Do you object to Med-Scribe, Inc. making inquiries regarding your qualifications and job performance?_____

If so, where?_____

Where did you learn about Med-Scribe, Inc.?_____

Have you applied to Med-Scribe, Inc in the past?_____ If so, when?_____

WORK EXPERIENCE: Start with the most recent position first. (Incompleteness will not be interpreted in your favor)

DATES OF EMPLOYMENT: Individual jobs need to be listed and questioned answered for each position held for the last 5 years.

1.Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

2. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

3. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

4. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

5. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

6. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

7. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

8. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

9. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

10. Start: _____ End: _____ Starting Salary: _____ Ending Salary: _____

Name and address of employer: _____

Phone: (___) _____ Hours per week: _____ Position: _____

Name and Title of supervisor: _____

Reason for leaving: _____

Description of job responsibilities: _____

_____

I declare that the statements made in this application (including the statements made in any accompanying papers) are true and correct. I understand that falsification of this application is grounds for immediate termination.

Signature: _____ Date:_____

MED-SCRIBE

HEALTHCARE RECRUITERS

Voluntary Information

Med-Scribe Inc is an Equal Opportunity Employer. We consider applicants for positions without regard to sex, race, color, religion, national origin, age, veteran's status, disability, or any other legally protected status.

We request your cooperation in providing the following information which will be used in accordance with federal and state statutes and regulations regarding Equal Opportunity. Providing this information is voluntary. All information received remains separate from your employment application and is not used in any way during the interviewing or hiring process and is kept separately from employment documents.

If you choose not to provide this information, check the space below indicating your decision

Date:_____

Position Applied For:_____

First Name:_____

Last Name:_____

Source:_____ (where you heard about this job)

GENDER: ☐ Male ☐ Female

RACE/ETHNIC GROUP:

☐ Caucasian
☐ Black or African American
☐ Hispanic or Latino
☐ Asian
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Two or more races
☐ Decline to answer

VETERAN STATUS:

Classifications of *protected veteran* are defined as follows:

- A "**disabled veteran**" is either a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under

laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service-connected disability.

- A "**recently separated veteran**" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "**active duty wartime or campaign badge veteran**" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "**armed forces service medal veteran**" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

☐ I identify as one or more of the classifications of *protected veteran* listed above.

☐ I am **not** a *protected veteran*.

Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 1/31/2017

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities. [i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- ☐ YES, I HAVE A DISABILITY (or previously had a disability)
- ☐ NO, I DON'T HAVE A DISABILITY
- ☐ I DON'T WISH TO ANSWER

Your Name _____ Today's Date _____

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about his form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.