

**Buchanan Family Medical Center**  
**Employment Application**

Pre-employment Questionnaire – An Equal Opportunity Employer  
**To be considered for employment, each item must be completed including wage information.**  
**Thank you!**

**Personal Information:**

Full Name:		Today's Date:
Present Present Addr, City, St, Zip:		
Permanent Addr, City, St, Zip:		
Social Security #:		Are you 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Ph:	Cell Ph:	Other Ph:

**Desired Employment:**

Position:	Date you can start:	Desired hourly wage:
Ideal number of hours you'd like to work in a week:	Minimum:	Maximum:
Our office is staffed Monday through Thursday 7:30 am – 9:00 pm and Fridays 7:30 am – 4:30 pm Please list any time periods that you would not be available during those hours – if you are available all hours then please state that:		
While our office provides employees with many free services in our office, we do not provide a health insurance plan for employees. Would this be an acceptable arrangement for you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, may we inquire of your present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you applied to this office before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when?	
Who referred you to this office? <input type="checkbox"/> Newspaper Advertisement <input type="checkbox"/> Friend <input type="checkbox"/> Other: (explain)		

**Education/Training:**

School Level	Name and Location of School	# of Yrs Attended	Did You Graduate?	Subjects Studied
Elementary			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Middle			<input type="checkbox"/> Yes <input type="checkbox"/> No	
High			<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other School			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current educational course:		Expected graduation date:		
Special study and/or training/skills:				

**Former Employers:** (List below the last four employers, starting with the most recent.)

Present/Last Employer:		
Emp Addr, City, St, Zip:		
Starting Date:	Leaving Date:	Job Title:
Hourly Start Salary:	Hourly Final Salary:	May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor:	Title:	Ph:
Description of Work:		
Reason for Leaving:		

Previous Employer:		
Emp Addr, City, St, Zip:		
Starting Date:	Leaving Date:	Job Title:
Hourly Start Salary:	Hourly Final Salary:	May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor:	Title:	Ph:
Description of Work:		
Reason for Leaving:		

Previous Employer:		
Emp Addr, City, St, Zip:		
Starting Date:	Leaving Date:	Job Title:
Hourly Start Salary:	Hourly Final Salary:	May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor:	Title:	Ph:
Description of Work:		
Reason for Leaving:		

Previous Employer:		
Emp Addr, City, St, Zip:		
Starting Date:	Leaving Date:	Job Title:
Hourly Start Salary:	Hourly Final Salary:	May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor:	Title:	Ph:
Description of Work:		
Reason for Leaving:		

**Military Service Record:**

Service Branch:	Discharge Date:	Rank:
Description of Military Experience:		

**Legal and Licensing Information:**

Please indicate all medical licenses you have or have had: <input type="checkbox"/> I've never had any medical license <input type="checkbox"/> DO <input type="checkbox"/> MD <input type="checkbox"/> PA-C <input type="checkbox"/> APRN <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> CMA <input type="checkbox"/> Other			
State:	License #:	State:	License #:
State:	License #:	State:	License #:
Has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice your trade with reasonable skill and safety? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain in detail on a separate paper.)			
Have you been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain in detail on a separate paper.)			
If you are licensed, has your license in any state been voluntarily or involuntarily revoked, suspended, restricted, or conditioned by a board or other licensing authority? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never Licensed (If yes, please explain in detail on a separate paper.)			
Have you ever been denied licensure or the privilege of taking an examination by any state board or licensing authority? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain in detail on a separate paper.)			
Have you ever been the subject of a Medicare, Medicaid, or insurance fraud investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain in detail on a separate paper.)			
Have you ever been excluded from the Medicare, Medicaid, or other state or federal health care program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain in detail on a separate paper.)			
Have you been arrested for a felony charge in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been convicted for a felony charge or convicted for a misdemeanor charge? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes for either question, please explain in detail on a separate paper – this will not necessarily exclude you from consideration.)			

**References:** (Please give the names of three or four persons you are not related to who can provide information about you. Three should be persons you have known at least one year and one should be a person residing or working in the Buchanan, Michigan area.)

Name	Phone Number(s)	How Acquainted	Years Acquainted
1.		<input type="checkbox"/> Business <input type="checkbox"/> Personal	
2.		<input type="checkbox"/> Business <input type="checkbox"/> Personal	
3.		<input type="checkbox"/> Business <input type="checkbox"/> Personal	
4.		<input type="checkbox"/> Business <input type="checkbox"/> Personal	

**Other Information:**

Many individuals have had experiences outside the workplace that display qualities that could be useful in the workplace. Examples of this would be: coach for little league, secretary of township board, chaperone for school events, etc. You may share below any such experiences that you've had that fit this description. Explain what personal qualities were involved that might be useful in the workplace.

**Personal Characteristics:**

Please list what you believe are your top three best personal characteristics.

- 1.
- 2.
- 3.

**Reason for employment:**

Please write a brief paragraph on why you think you should be hired for this office.

**Authorization:**

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application may be grounds for discipline or dismissal. I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information. I waive any written notice of such records that may be required by state or law. I authorize Buchanan Family Medical Center to obtain my credit report and criminal history for use in considering my employment application and, if hired, for continued employment and/or promotions. I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative."

Signed:

Date:

Revised 06/29/2010 rp

Buchanan Family Medical Center • 1045 East Front Street, Buchanan, MI 49107

Phone: 269 – 695 – 5540 • Fax: 269 – 695 – 2590

E-mail: [jobs@buchananfamilymed.com](mailto:jobs@buchananfamilymed.com)