



Employment Application

APPLICANT INFORMATION

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NAME:

LAST NAME FIRST NAME M.I.

ADDRESS:

STREET CITY ZIP

DOB: _____ PHONE: _____

CELL: _____ E-MAIL: _____

SOCIAL SECURITY NUMBER: _____

POSITION APPLYING FOR: _____ AVAILABLE TO START: _____

CAN YOU TRAVEL IF A JOB REQUIRES IT? YES NO

REFERRED BY: _____

IF YOU ARE UNDER 18 YEAR OF AGE, CAN YOU PROVIDE REQUIRED PROOF OF YOUR ELIGIBILITY TO WORK? YES NO

ARE YOU A CITIZEN OF THE UNITED STATES? YES NO

IF NO, ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES? YES NO

(Proof of citizenship or immigration status will be required upon employment)

HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR _____ YES _____ NO
FELONY? _____ YES _____ NO

IF YES, EXPLAIN: _____

EDUCATION

HIGH SCHOOL: _____ ADDRESS: _____

YEAR GRADUATED: _____ DEGREE: _____

COLLEGE: _____ ADDRESS: _____

YEAR GRADUATED: _____ DEGREE: _____

LICENSES/CFRTIFICATION

-Describe any professional licenses, certifications, or registrations pertinent to the position to which you are applying. (You may also attach your resume) _____

KNOWLEDGE / SKILLABILITIES / LANGUAGES

List the knowledge, skill, ability and/or language you possess that are relevant to *the* position you seek (e.g. typing speed, computer knowledge, etc. or you may attach your resume) _____

PREVIOUS EMPLOYMENT

#1: COMPANY: _____ PHONE: _____
ADDRESS: _____ SUPERVISOR: _____
JOB TITLE: _____ STARTING SALARY:\$ _____
RESPONSIBILITIES: _____ ENDING SALARY:\$ _____

WORKED FROM _____ TO _____ REASON FOR LEAVING _____

MAY WE CONTACT YOUR PREVIOUS SUPERVISOR FOR A REFERENCE: _ YES _ NO

#2: COMPANY: _____ PHONE: _____
ADDRESS: _____ SUPERVISOR: _____
JOB TITLE: _____ STARTING SALARY:\$ _____
RESPONSIBILITIES: _____ ENDING SALARY:\$ _____

WORKED FROM _____ TO _____ REASON FOR LEAVING _____

MAY WE CONTACT YOUR PREVIOUS SUPERVISOR FOR A REFERENCE: _ YES _ NO

#3: COMPANY: _____ PHONE: _____
ADDRESS: _____ SUPERVISOR: _____
JOB TITLE: _____ STARTING SALARY:\$ _____
RESPONSIBILITIES: _____ ENDING SALARY:\$ _____

WORKED FROM _____ TO _____ REASON FOR LEAVING _____

MAY WE CONTACT YOUR PREVIOUS SUPERVISOR FOR A REFERENCE: _ YES _ NO

RE'FERENCES



LATINO
MEDICAL CENTER

21301 NW 2nd Ave,
Miami Gardens, FL 33169
TEL: (305) 947-47777
FAX: (786) 657-2623

NAME: _____

RELATIONSHIP: _____

COMPANY: _____

PHONE: _____

NAME: _____

RELATLONSHIP: _____

COMPANY: _____

PHONE: _____

NAME: _____

RELATIONSHIP: _____

COMPANY: _____

PHONE: _____

DISCLAIMER AND SIGNATURE

I certify herein that all information given herein, and in all other documentation presented as part of the application process, is true and complete to the best of my knowledge. I authorize investigation of all information contained in this application for employment and other submitted documents as may be necessary in arriving at an employment decision. This application for employment shall be considered active for a period of time not to exceed 60 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time and if so, must reapply. I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization. In the event of employment, I understand that false or misleading information given in my application, other documents, and interview(s) may result in termination. I understand, also, that I am required to abide by all rules and regulations of Latino Medical Center if hired.

I herein further certify that I have not been or are currently excluded from participating in any federal or state health care program and have not been criminally convicted of any wrong doings regarding these programs.

I understand that Latino Medical Center may verify my status utilizing the "List of Excluded Individuals Entities" from the OIG.

Applicant's Signature

Date