TherapyWorks

Vibrant Health ~ Caring Professionals

EMPLOYMENT APPLICATION

TherapyWorks P.A. is committed to the provision of equal employment opportunities to its applicant regardless of race, color, sex, age, religion, national origin, disability, veteran status or any other characteristic as protected by law. This application is intended to allow you to provide our organization with information from which your suitability for the position(s) for which you are applying can be determined.

PERSONAL DATA

NAME, LAST	FIRST	M.I.	DATE
ADDRESS			HOME PHONE
CITY, ST., ZIP			CELL PHONE
POSITION DESIRED		SOC. SEC. #	EMAIL

WORK HOURS PREFERRED	FULL TIME	PART TIME	DAYS	EVENINGS	WEEKENDS

AFTER EMPLOYMENT CAN YOU SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES?	ARE YOU 18 YEARS OF AGE OR OLDER?
HAVE YOU EVER BEEN CONVICTED OF A FELONY OR, WITHIN THE LAST FIVE YEARS, A MISDEMEANOR WHICH RESULTED IN INPRISONMNET?	
AFTER REVIEW OF THE POSITION RESPONSIBILITIES, DO YOU HAVE ANY LIMITATIONS WHICH WOULD AFFECT YOUR ABILITY TO PERFORM THE JOB APPLIED FOR? IF YES, WHAT CAN BE DONE TO ACCOMMODATE YOUR LIMITATION?	

WOULD YOU AGREE TO TAKE A PHYSICAL EXAM?	DATE AVAILABLE	SALARY DESIRED

EDUCATION

	NAME OF SCHOOL	LOCATION	COURSE OF STUDY	NO. OF YEARS COMPLETED	DEGREE/ DIPLOMA
HIGH SCHOOL					
COLLEGE					
GRADUATE					
BUSINESS					
TRADE/ TECHNICAL					

PROFESSIONAL REGISTRATION LICENSURE OR CERTIFICATION	STATE	I.D. NO.	EXPIRATION

OTHER STATES WHERE FORMERL OR CURRENTLY REGISTERED? ______________________________

IS YOUR PROFESSIONAL LICENSE CURRENTLY SUSPENDED OR REVOKED IN ANY STATE? __________

IF YES, EXPLAIN: ____

HAVE YOU EVER HAD YOUR PROFESSIONAL LICENSE SUSPENDED OR REVOKED IN ANY STATE? ______

IF YES, EXPLAIN: ____

EMPLOYMENT HISTORY

COMPLANY NAME	DATES EMPLOYED (MO/YR) FROM TO
ADDRESS	TELEPHONE ( )
CITY, ST, ZIP	WEEKLY PAY START FINAL
TITLE/POSITION	NAME & TITLE OF SUPERVISOR
BREIFLY DESCRIBE YOUR DUTIES:	PERSON(S) OF REFERENCE
	REASON FOR LEAVING

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BREIFLY DESCRIBE YOUR DUTIES:	PERSON(S) OF REFERENCE
	REASON FOR LEAVING

MILITARY: HAVE YOU EVER SERVED IN THE ARMED FORCES?

DESCRIBE ANY TRAINING RECEIVED RELEVANT TO THE POSITION FOR WHICH YOU ARE APPLYING:

CERTIFICATION

I certify that the answers given by me in the foregoing questions and statements are true and correct without consequential omission of any kind. I agree that the company shall not be liable in any respect if my employment is terminated because of falsity or statements, answers, or omissions made by me in this application. I also authorize the companies, schools, or persons named above to give any information regarding my employment, character, and qualifications. I hereby release said companies, schools, or persons from all liability for any damage for issuing this information. I certify that all statements and answers to questions about my health are true and were made by me without reservations. I expressly waive all provisions of law prohibiting any physician, person, hospital, or other institution that has or may hereafter attend or furnish me with treatment from disclosing to the company any knowledge or information thereby acquired. I understand that any misleading or incorrect statement may render this application void, and if employed, cause for termination. I understand that this employment application and any other Company documents are not contracts of employment, and that any individual who is hired may voluntarily leave employment, and I may be terminated by the employer at any time for any reason. I understand that any oral or written statements, including statements in staff member handbooks, to the contrary are hereby expressly disavowed and should not be relied upon by any prospective or existing staff member.

Applicant's Signature ______________________________ Date ____________

This application will remain active for a period of 90 days.
You must complete another application form should you wish to remain on file.

Identification Code ________________________

Authorization for Release of Information

I hereby request and authorize the Kansas Bureau of investigation to furnish TherapyWorks with criminal information as described in K.S.A. 1985 Supp. 22-4701 (b). This includes information defined with K.A.R. 10-1-1 (b), (c), and (d).

I voluntarily waive all right of recourse and release you from liability for compliance with this authorization.

FULL NAME ____

ANY OTHER NAME USED ____

CURRENT ADDRESS ____

SEX ________ RACE ____________ BIRTHDATE ________________________________

SOC SEC NO. ____

ADDITIONAL INFORMATION ____

Applicant's Signature ________________________________ Date ____________________

KBI Response:

AFFIRMATIVE ACTION
SELF IDENTIFICATION INFORMATION

Completion of this portion of the application is strictly voluntary and will not affect your opportunity for employment with TherapyWorks in any way. In compliance with federal government requirements, we ask that you complete this information to help us evaluate our Affirmative Action Program. Please return the form as part of your application package.

NAME ____

SOC SEC No. _______________________________________

Sex

Male

Female

Ethnicity

Black

Asian or Pacific Islander

Native American or Alaskan Native

Hispanic

White

Disabled Status

Hearing Impaired

Visually Impaired

Speech Impaired

Mobility Impaired

Medical Condition: ______________________________

Other please explain: ____________________________

Military Status

Disabled Veteran

Vietnam Veteran

Disabled Vietnam Veteran