



THIS CLINIC IS AN EQUAL
OPPORTUNITY EMPLOYER
AND DOES NOT
DISCRIMINATE BECAUSE OF
AGE, SEX, RACE, CREED,
COLOR, NATIONAL ORIGIN,
HANDICAP OR DISABILITY

APPLICATION FOR EMPLOYMENT

PERSONAL DATA					DATE: _____	
LAST		FIRST		MIDDLE	SOCIAL SECURITY NO.	BIRTHDATE (DAY & MONTH)
NAME						
STREET		CITY	STATE	ZIP	AREA CODE / NUMBER	
ADDRESS						
STREET		CITY	STATE	ZIP	AREA CODE / NUMBER	
PERMANENT ADDRESS						
ALTERNATE PHONE					AREA CODE / NUMBER	
ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THIS COUNTRY? YES NO (PROOF OF U.S. CITIZENSHIP OR IMMIGRATION STATUS WILL BE REQUIRED UPON EMPLOYMENT)						
HAVE YOU EVER BEEN CONVICTED OF A FELONY, OR PLED GUILTY OR NO CONTEST TO A FELONY? YES NO IF YES, EXPLAIN (A YES RESPONSE DOES NOT NECESSARILY PRECLUDE CONSIDERATION FOR HIRING.)						
ARE YOU ABLE TO MEET ATTENDANCE REQUIREMENTS OF THE POSITION? YES NO						
DO YOU HAVE RELATIVES WORKING FOR THIS CLINIC? YES RELATIONSHIP? NO						

JOB PREFERENCE	
POSITIONS APPLYING FOR IN ORDER OF PREFERENCE 1. 2. 3.	
TYPE OF EMPLOYMENT DESIRED () REGULAR FULLTIME PART-TIME	
ARE YOU WILLING TO WORK WEEKENDS AND/OR HOLIDAYS? YES NO	WHAT IS YOUR WAGE/SALARY REQUIREMENT?
WHEN WILL YOU BE AVAILABLE TO BEGIN WORK?	HAVE YOU EVER WORKED HERE BEFORE? () YES () NO

EMPLOYMENT HISTORY

STARTING WITH PRESENT OR MOST RECENT EMPLOYER, LIST PREVIOUS EMPLOYMENT					
EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	()RESIGNED () DISCHARGED REASON:	

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	()RESIGNED () DISCHARGED REASON:	

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	()RESIGNED () DISCHARGED REASON:	

EMPLOYER (PRESENT OR MOST RECENT)			ADDRESS/PHONE NUMBER	TYPE OF WORK	SUPERVISOR
DATE HIRED	DATE ENDED	RATE OF PAY	YOUR NAME WHILE EMPLOYED	()RESIGNED () DISCHARGED REASON:	

EDUCATION AND TRAINING				
SELECT LAST GRADE COMPLETED: GRAMMAR: 5 6 7 8 HIGH SCHOOL: 9 10 11 12 COLLEGE: 1 2 3 4 5 6 7 8				
NAME OF COLLEGE/UNIVERSITY	DEGREE	MAJOR/FIELD	DATE GRADUATED	
VO-TECH (Including Nursing)	CERTIFICATE/LICENSE	MAJOR/FIELD	DATE GRADUATED	
BUSINESS SCHOOL/SPECIAL TRAINING	DEGREE/CERTIFICATE	MAJOR/FIELD	DATE GRADUATED	
TYPE OF LICENSE IF MEMBER OF TRADE OR PROFESSION	LICENSE NO.	ISSUING DATE	EXPIRATION DATE	LIC. VERIFIED BY/DATE
MACHINES AND EQUIPMENT YOU CAN OPERATE		PAST ELECTRONIC MEDICAL HEALTH RECORDS EXPERIENCE PLEASE LIST:		

MILITARY SERVICE		
BRANCH	DATES OF SERVICE FROM TO	DESCRIBE MILITARY OCCUPATION/EXPERIENCE

SOURCE INFORMATION	
PLEASE CHECK THE ITEM BELOW WHICH BEST DESCRIBES WHY YOU ARE APPLYING HERE:	
ANSWERED NEWSPAPER AD	REPUTATION OF OKLAHOMA ALLERGY & ASHTMA CLINIC
RECOMMENDED BY A FRIEND/RELATIVE	WALK-IN APPLICANT
CONTACTED BY RECRUITER	OTHER, EXPLAIN
OKLAHOMA STATE EMPLOYMENT SERVICE	

EMPLOYMENT AGREEMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I testify that all answers given in this application are true and correct to the best of my knowledge and belief. I understand that any omission or misrepresentation will disqualify my application or be cause for dismissal. I also authorize the authorities of the Oklahoma Allergy and Asthma Clinic to investigate all statements and references and release the Clinic from any and all liability resulting from such investigation. I consent to medical examinations or other tests required for the position I am applying for and understand that if I am employed, I will be on a provisional basis for 180 days from the date of employment. Upon termination, I authorize the release of reference information on my work. I also agree, if employed, to serve to the best of my ability and to abide by the policies established by Clinic administration. I understand that this application for employment by this Clinic does not constitute an employment contract. Should employment occur, either party at any time with or without notice, and with or without cause, may terminate the relationship.

SIGNED:-----DATE: -----

APPLICANT __ DO NOT FILL BELOW THIS LINE

SUPERVISOR/DEPARTMENT HEAD

MO/DAY/YEAR STARTING	DEPARTMENT	POS. TITLE	WAGE / SALARY
REGULAR	FULLTIME	PART-TIME	HOURS/DAYS OF WEEK
SIGNATURE OF SUPERVISOR	SIGNATURE OF DEPARTMENT HEAD	SIGNATURE OF EXECUTIVE DIRECTOR	

Please review your application before submitting, save this application and email it to "careers@oklahomaallergy.com".