

BOND COMMUNITY HEALTH CENTER, INC.
1720 South Gadsden Street
Tallahassee, FL 32301



PROVIDER APPLICATION FOR EMPLOYMENT
(Please print or type)

Date: _____

POSITION APPLIED FOR				MINIMUM SALARY ACCEPTABLE	
LAST NAME FIRST MIDDLE MAIDEN				SOCIAL SECURITY	
ADDRESS			FLOOR/SUITE/ROOM		TELEPHONE NUMBER
CITY		STATE		ZIP	
ARE YOU A U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF NOT A U.S. CITIZEN, HAVE YOU THE RIGHT TO REMAIN PERMANENTLY IN THE U.S.? <input type="checkbox"/> STUDENT <input type="checkbox"/> PERMANENT <input type="checkbox"/> J-1 VISA <input type="checkbox"/> VISA	
DO YOU SPEAK ANY LANGUAGES(S) IN ADDITION TO ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list:				HOW DID YOU HEAR ABOUT BOND COMMUNITY HEALTH CENTER, INC?	
HAS YOUR LICENSE EVER BEEN: <input type="checkbox"/> Limited <input type="checkbox"/> Suspended <input type="checkbox"/> Revoked in any jurisdiction? <input type="checkbox"/> NO				HAVE YOU EVER HAD A PROFESSIONAL MALPRACTICE LIABILITY ACTION COMMENCED AGAINST YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide summary and outcome on separate sheet: List your malpractice carrier _____	
WHEN CAN YOU START?					

EDUCATION

	NAME & ADDRESS OF SCHOOL	CONCENTRATION	DID YOU COMPLETE?	DATES	DEGREE OR DIPLOMA
COLLEGE					
MEDICAL/DENTAL SCHOOL					
INTERNSHIP					
RESIDENCY					
OTHER					

ADDITIONAL INFORMATION

SPECIALTY BOARD CERTIFICATIONS <input type="checkbox"/> Eligible <input type="checkbox"/> Certified Date: _____	STATE OF FLORIDA LICENSE NO. _____ Expiration Date: _____ NPI NO. _____	DEA REGISTRATION NO/UPIN NO. _____ / _____ Expiration Date: _____ Medicaid Provider No. _____ Medicare Provider No. _____
HOSPITAL AFFILIATIONS _____ _____	CAPACITY _____ _____	DATES _____ _____

EMPLOYMENT RECORD (list most recent positions first)

DATES	NAME & ADDRESS OF EMPLOYER	POSITION	LAST SALARY	REASON FOR LEAVING	SUPERVISOR & CONTACT TELEPHONE NUMBER
FROM TO					
FROM TO					
FROM TO					
FROM TO					
FROM TO					

REFERENCES

NAME & ADDRESS	YEARS KNOWN	OCCUPATION	PHONE NUMBER

Consent to the release of information by any former employer to Bond Community Health Center, Inc.

I certify that all of the statements made by me on this application are true and may be investigated. If any are said to be false, this will constitute sufficient reason for my dismissal. If I am offered a position I consent to a pre-employment physical and any future medical examinations as may be required by the Center. I have been informed that Bond Community Health Center, Inc. is an equal employment opportunity employer and does not discriminate on the basis of race, ethnicity, religion, gender, sexual orientation, age, disability or marital status. All information obtained during interview and selection process will be used only for lawful purposes. Bond Community Health Center, Inc. reserves the right to conduct random drug testing.

SIGNATURE: _____

DATE: _____