# 

# EMPLOYMENT APPLICATION

## Incomplete Applications Will Not Be Considered

**(Please Print)**

**POSITION OF INTEREST**

|  |  |
| --- | --- |
| Job Title: | Department: |
| I am available for:  Full Time  Temporary  Part Time  Other: | Date Available to Work: |

### PERSONAL DATA

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name | First Name | Middle Name | Other Names Under Which Employed |
| Street Address | City | State | Zip Code |
| Home Telephone | Office/Message/Cell Telephone | Email Address |  |

|  |  |
| --- | --- |
| If hired, can you provide proof of eligibility to work in the U.S.A. as specified by the Immigration Reform and Control Act of 1986?  Yes No | If less than 18 years of age, can you submit a work permit?  Yes  No |

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| --- |
| Are you currently excluded by any federal agency from participating in any federally funded health care program?  Yes  No  Note: SCPMCS reviews the Office of the Inspector General’s Exclusion List prior to any individual beginning employment. |

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| Do you have any relatives or friends employed at SCPMCS?  Yes  No  If yes, please provide the following information: Name:       Relationship: |

#### REFERRAL SOURCE

|  |  |  |  |
| --- | --- | --- | --- |
| Advertisement (specify publication) | Internet (specify web site) | Agency/School (specify) | SCPMCS Web Site |
| Employee Referral (specify name) | Personal Referral (specify name) | Other (specify source) | In Person |

##### EDUCATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of School  (High School, College, Business, Technical) | Address | # Yrs  Attended | Type of Degree | Major |
| High School |  |  |  |  |
| College/Other |  |  |  |  |
| College/Other |  |  |  |  |

**PROFESSIONAL LICENSES, REGISTRATIONS, OR CERTIFICATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type | State | Number | Expiration Date | Years of Certified Experience |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

##### SKILLS

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| --- |
| Typing       WPM  ICD-9 / ICD-10 Coding  Medical Terminology  Data Entry: Alpha       SPM Numeric       SPM  CPT Coding  Office Equipment (please list)  Computer Skills (please list)  Other Skills (please list) |

##### EMPLOYMENT HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **Starting with current date, please list all periods of time, including all employment, unemployment, school, U.S. armed forces service, volunteer activity, etc. A resume may be attached as a supplement but not as a substitute. Please use separate paper for additional comments/explanations.** | | | |
| Name of Employer | From (mo/yr) | Title and Duties | Reason for Leaving |
| Street Address | To (mo/yr) |  |  |
| City State Zip | Hours per week |  |  |
| Supervisor/Title Telephone |  |  |  |
| Name of Employer | From (mo/yr) | Title and Duties | Reason for Leaving |
| Street Address | To (mo/yr) |  |  |
| City State Zip | Hours per week |  |  |
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| Street Address | To (mo/yr) |  |  |
| City State Zip | Hours per week |  |  |
| Supervisor/Title Telephone |  |  |  |

IF EMPLOYED, MAY WE CONTACT YOUR PRESENT EMPLOYER?  Yes  No

##### APPLICANT’S STATEMENT

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| --- |
| I understand that the information contained in this application form is true and correct to the best of my knowledge. I authorize Southern California Physicians Managed Care Services (SCPMC) to contact my present and past employers, schools, references and other sources deemed appropriate to consider my application. Further, I release all parties from any and all liability from furnishing such information to SCPMCS as well as from the use or disclosure of such information by SCPMCS. All facts stated in the application are open for investigation. I understand that any false or misleading information, or any material omission may result in my failure to receive an offer or, if I am hired, my termination from employment.  I agree to adhere to the policies, procedures and standards of SCPMCS. I understand and agree that any employment at SCPMCS is at will, and can be terminated with or without cause or advance notice, at any time, either at my option or at the option of SCPMCS. I also understand that this supersedes any prior representation or promise to the contrary, and may only be modified in writing, signed by me and the Chief Executive Officer (CEO).  I understand that all offers of employment are contingent on the provision of satisfactory proof of an applicant’s identity and legal authority to work in the United States, and that I am not eligible for employment with SCPMCS if I am, at any time, subject to exclusion from participating in any federally funded health care program. I also understand I must reapply after 90 days if the job remains unfilled.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Signature Date |

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| SCPMCS does not discriminate on the basis of race, national origin, religion, gender, sexual preference, age, disability, veteran’s status or any other category protected by the applicable federal, state or local law. SCPMCS is an EEO employer. |