

## EMPLOYMENT APPLICATION

### PERSONAL INFORMATION

Name (Last)	First	Middle	Date / /
Home Address		City	State Zip
Home Telephone ( )	Cellular Phone ( )	Business Phone ( )	May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email			

### CAREER

Position/Type of Work Desired	Are you 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Available for Employment / /	How did you hear of this position/hospital?					
Did an employee refer you? Who?	Desired Salary \$	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Shift Work <input type="checkbox"/> Temporary <input type="checkbox"/> Summer						
Days and hours available								
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Are you willing to relocate? <input type="checkbox"/> Yes <input type="checkbox"/> No
From								
To								

### EDUCATION

Type of School	Name and Location of School	Degree/Area of Study	Number of Years Attended	Graduated (check one)
High School	Name Address			<input type="checkbox"/> Yes
	City State Zip			<input type="checkbox"/> No
College	Name Address			<input type="checkbox"/> Yes
	City State Zip			<input type="checkbox"/> No
Graduate School	Name Address			<input type="checkbox"/> Yes
	City State Zip			<input type="checkbox"/> No
Other	Name Address			<input type="checkbox"/> Yes
	City State Zip			<input type="checkbox"/> No

### MILITARY

Period of Active Duty (Mo./Yr. to Mo./Yr.)	Branch of Service	Highest Rank	Principal Duties Performed?
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## EMPLOYMENT HISTORY

List employment starting with your most recent position. You may include a description of verified work performed on a volunteer basis.

Dates	Name and Address of Employer	Position Held and Supervisor	List of Major Duties	Salary or Wages	Reason for Leaving
From: (mo./yr.) /	Name	Your Job Title		Starting	
To: (mo./yr.) /	Address	Supervisor		Final	
	City & State Phone				
From: (mo./yr.) /	Name	Your Job Title		Starting	
To: (mo./yr.) /	Address	Supervisor		Final	
	City & State Phone				
From: (mo./yr.) /	Name	Your Job Title		Starting	
To: (mo./yr.) /	Address	Supervisor		Final	
	City & State Phone				

How many pets do you have as part of your family today?	Please list your family of pets you are closest to (up to three):
Are you involved in any pet/animal related associations or organizations? If so, which ones?	
Special training or skills within your field:	Computer skills: <input type="checkbox"/> Macintosh <input type="checkbox"/> PC List software you have used/taken classes in:
States Licensed in: (DVM/LVT/CVT)	License #: _____ Licenses Pending: _____
Do you have a current DEA License?	States Federally Accredited in: _____
Career Related Clubs or Organizations in which you participate:	
Are you able to stoop, twist, bend, stand for a long period of time and lift up to 50 lbs. occasionally with or without accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If selected for employment, are you able to provide current original documents of proof of your eligibility to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## REFERENCES

Business References (do not list relatives):				
Name	Address	Work Phone Number	Title	Years Known

I certify that all information given on this application is true and correct. I understand that Family Pet Hospital will investigate my work and personal history and I authorize all persons, schools, companies, credit bureaus, and law enforcement agencies to supply any information concerning my background and release them from any liability and responsibilities arising from their doing so. I also understand if hired, my employment would be "at will" which means I may be terminated at any time for any reason. I further understand that, if I am employed, any false statement, misrepresentation, or omission of facts on this application or on any supporting documents, regardless of when discovered to be false, will result in my immediate dismissal. And if I am offered employment, I will, as a condition of employment, be required to submit proof of my identity and legal right to work in the US within three (3) business days of my hire date. Any change to the policies stated above must be in writing and signed by the Chief of Staff/owner of hospital in order to be effective.

**SIGNED AND DATE**

Applicant's Signature X \_\_\_\_\_ Date \_\_\_\_\_

**This statement may be photocopied for background investigation**