



P.O. Box 361095
Melbourne, FL 32936
Fax: (321) 435-0100

PERSONAL INFORMATION

Name (Last, First, MI)		Social Security Number		Today's Date:
Home Street Address	Apt. #	City	State	Zip
Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Phone	Cell Phone	Best time to call
Have you been previously employed by MEDICAL ASSOCIATES OF BREVARD ? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES, WHEN:		Which MD:	Why did you leave:	
Other Names Under Which You Have Worked:				
Have you ever been excluded, suspended, debarred or otherwise sanctioned from participation in any federal healthcare program? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain:				

DESIRED EMPLOYMENT

<input type="checkbox"/> MEDICAL ASSISTANT <input type="checkbox"/> BILLING <input type="checkbox"/> FRONT DESK <input type="checkbox"/> _____	Date you can start	Salary Desired?
--	--------------------	-----------------

EDUCATION

School Level	Name & Location of School	# of Years Attended	Did you Graduate?	Subjects Studied
High School				
College				
Trade, Business or Correspondence School				

LICENSE AND CERTIFICATIONS

Type: _____	State Issued: _____
License Number: _____	Expiration Date: _____
Type: _____	State Issued: _____
License Number: _____	Expiration Date: _____

GENERAL

Is there anything you do not feel comfortable in performing as part of the duties for the type of position you are applying? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please specify:
Are you certified to perform CPR? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can you do phlebotomy with ease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you know Medical Terminology? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current typing speed:	
List any Special Skills, office equipment knowledge, computer systems knowledge:		

FORMER EMPLOYERS

List below last three employers, starting with the most recent one first.

Name of Present or Previous Employer:			
Address:		City:	State: Zip:
From:	To:	Job Title:	
Hourly Starting Salary:	Hourly Final Salary:	May we contact your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor's Name & Phone Number:			
Description of work:			
Reason for leaving:			

Name of Previous Employer:			
Address:		City:	State: Zip:
From:	To:	Job Title:	
Hourly Starting Salary:	Hourly Final Salary:	May we contact your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor's Name & Phone Number:			
Description of work:			
Reason for leaving:			

Name of Previous Employer:			
Address:		City:	State: Zip:
From:	To:	Job Title:	
Hourly Starting Salary:	Hourly Final Salary:	May we contact your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor's Name & Phone Number:			
Description of work:			
Reason for leaving:			

Medical Associates of Brevard LLC

PRE-EMPLOYMENT DRUG TESTING POLICY

All job applicants at this Company will undergo screening for the presence of illegal drugs as a condition for employment.

Applicants will be required to voluntarily submit to a urinalysis test at a laboratory chosen by the Company, and by signing a consent agreement, will release the Company from liability.

(Any applicant with positive results will be denied employment at that time.)

The Company will not discriminate against applicants for employment because of past drug abuse of drugs or alcohol. It is the current abuse of drugs or alcohol, which prevents employees from properly performing their jobs that the Company will not tolerate.

PRE-EMPLOYMENT AGREEMENT

PLEASE READ CAREFULLY

I freely and voluntarily agree to submit to a urinalysis (drug screen) as part of my application for employment. I understand that either refusal to submit to the urinalysis screen or failure to qualify according to the minimum standards established by the Company for this screen might disqualify me from further consideration for employment.

I further understand that upon commencement of employment with Company, I may again be required to submit to urinalysis screen. I understand that refusal to take a requested urinalysis screen or failure to meet the minimum standards set for the screen may result in immediate suspension or discharge.

In the event that employment commences prior to the Company receiving the drug test results, I understand that I will be immediately terminated if the result comes back positive, adulterated or substituted. I understand that a negative drug test result is required for consideration for permanent employment.

I have read in full and understand the above statements and conditions of employment.

Applicant's Signature

Date

Driver License Information:

State: _____

DL# _____