**PRE-EMPLOYMENT APPLICATION**

**WESTERN CAROLINA EAR, NOSE, AND THROAT SPECIALISTS, PLLC**

**WENZEL FACIAL PLASTIC SURGERY, PLLC**

*Please complete this form as thoroughly as possible. The information provided will be used to help us assess your qualifications for employment. All responses will remain confidential.*

**Personal Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* State: \_\_\_\_\_\_\_ ZIP Code: \_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred Contact Method: □ Phone □ Email

**Position Applied For**

* Position Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date Available to Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Desired Employment Type: □ Full-Time □ Part-Time □ Temporary

**Employment History**

*Please list your most recent employment first (or attach resume).*

1. **Employer Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Dates of Employment (from/to): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Contact Information (Phone/Email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Employer Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Dates of Employment (from/to): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Contact Information (Phone/Email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Continue on a separate sheet if necessary or attach CV/resume.)

**Education and Training**

* Highest Level of Education Completed: □ High School □ Associate's Degree □ Bachelor's Degree □ Master's Degree □ Other: \_\_\_\_\_\_\_\_\_\_\_
* Name of Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Year Graduated (or expected graduation date): \_\_\_\_\_\_\_\_\_
* Relevant Certifications/Training (include dates):

**Skills and Qualifications**

*Please check all that apply to you and describe your level of proficiency.*

* □ Medical Terminology: \_\_\_\_\_\_\_ (Beginner / Intermediate / Advanced)
* □ HIPAA Compliance: \_\_\_\_\_\_\_ (Beginner / Intermediate / Advanced)
* □ Patient Scheduling Systems: \_\_\_\_\_\_\_ (List Software Experience)
* □ Medical Billing and Coding: \_\_\_\_\_\_\_ (Beginner / Intermediate / Advanced)
* □ Electronic Health Records (EHR) Systems: \_\_\_\_\_\_\_ (List Software Experience)
* □ First Aid/CPR Certified: □ Yes □ No (If yes, expiration date: \_\_\_\_\_\_\_\_\_\_\_)
* □ Other Skills/Certifications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Availability**

* Days Available: □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday □ Sunday
* Hours Available: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Will you be willing to work weekends or evenings? □ Yes □ No

**References**

*Please provide at least two professional references.*

1. **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health and Physical Requirements**

1. Are you able to perform the essential duties of the position with or without reasonable accommodation? □ Yes □ No
2. Do you have any allergies or medical conditions that may impact your ability to perform specific job duties? □ Yes □ No
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you able to lift up to 25 lbs. regularly as required for some medical office duties? □ Yes □ No

**Legal and Background Information**

1. Have you ever been convicted of a felony? □ Yes □ No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have a valid driver’s license? □ Yes □ No (If applicable to the position)

**Acknowledgments and Signature**

* I certify that the information provided in this pre-employment questionnaire is accurate and complete to the best of my knowledge.
* I understand that any false or misleading information may result in the disqualification from consideration for employment or, if hired, dismissal from employment.
* I authorize the employer to conduct a background check, including but not limited to criminal, employment, and reference checks.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for completing this form. We look forward to reviewing your application