Lexington Women's Health, PLLC
1720 Nicholasville Road Ste 702
Lexington, KY 40503
Phone (859)264-8811
Fax(859) 264-8822

PERSONAL INFORMATION

(Last) (First) (Middle) Your Name:	Social Security#:
(Street) (City) (State) (Zip) Address:	
Telephone: ( )	Are you at least 18 years old? Yes ☐ No ☐
Position(s) you are applying for:	
Date available for work:	Rate of pay expected: _____ per
Work area preferred:	Days/shift desired:
Type of employment desired: Full time ☐ Part time ☐ Temporary ☐	Are you willing to work weekends and holidays? Yes ☐ No ☐
Have you ever been convicted of a felony? Yes ☐ No ☐ If yes, date and nature of conviction:	
Are you willing to substitute at another location? Yes ☐ No ☐	
List any relatives who work for Lexington Women's Health:	

EDUCATIONAL INFORMATION

Type of School	Dates Attended	School Name/City	Graduate? Yes ☐ No ☐	Major/ Course	Degree Received
High					
College					
Graduate					
Other					

List any professional license, certification, and/or registration you possess:	
States where registered:	Expiration Date:
Has your professional license, certification, and/or registration ever been suspended or revoked? Yes ☐ No ☐	
If yes, why?	
Do you authorize us to inquire about your licensure, certification, and/or registration with the appropriate licensing	

agency or board? Yes ☐ No ☐

EMPLOYMENT INFORMATION

List below all present and past employment, beginning with most recent.

Employer Name/Address/ Phone/Supervisor's Name	Dates of Employment	Job Title and Duties	Ending Salary	Reason for Leaving

May we contact the employers you listed? Yes ☐ No ☐
If no, explain:

Explain any periods of unemployment during the past five years:

Have you ever served in the U.S. Armed Forces? Yes ☐ No ☐
If yes, which branch?
Date entered: Date discharged:

List any other skills, training, or qualifications, not yet mentioned, which you think would benefit this organization:

List below three people we can call as references for you. These need to be **work** related, not family or friends.

Reference Name	How you know this reference	Reference Phone Number

APPLICANT CERTIFICATION AND AGREEMENT - READ CAREFULLY

I agree that:

I consent to all medical examinations and tests required by Lexington Women's Health, PLLC:

I release from liability all representatives of Lexington Women's Health, PLLC for any acts performed in good faith and without malice in connection with evaluating my application, competence, credentials, character, and qualifications and I release from liability any and all individuals and organizations who provide information to Lexington Women's Health, PLLC, in good faith and without malice, concerning my professional competence, credentials, character and other qualifications and I consent to the release of such information.

I understand that:

Lexington Women's Health, PLLC adheres to the "Employment at Will" doctrine that has been recognized by Kentucky courts. Under this doctrine, I am free, or the company is free to terminate my employment relationship at any time and for any reason.

I understand that the needs of Lexington Women's Health, PLLC may make overtime, shift work, a rotating work schedule, or a work schedule other than a standard schedule a mandatory condition of my employment. I also understand, upon termination of my employment, I must return any Company property issued to me or I will authorize the value of same to be deducted from my wages.

If employed, I understand that my employment is not guaranteed for a definite period of time. If my employment is terminated in the future, I understand that the Company is liable for my wages earned as of the date of my termination.

All statements made by the applicant on this application form will be checked for accuracy. Lexington Women's Health, PLLC offers equal employment opportunities to all persons without regard to race, color, religion, age, sex, national origin, or disability.

I certify that the information provided by me on this application is true to the best of my knowledge. Any false statements may result in termination of my employment.

_____ _____

Signature of Applicant Date

(PRINT NAME)	Last	First	Middle	Maiden	
(ADDRESS)	Street	City		State	Zip
Last Previous Address:					

I do hereby authorize any law enforcement agency to search their records for any arrest, convictions, or information they may have regarding me, and to make this information available to Lexington Women's Health, PLLC, 1720 Nicholasville Road, Ste 702, Lexington, Kentucky, prior to my employment or at any time during my employment.

Birthdate: Social Security #:

Applicant's Signature Date

Signature of person requesting above record

Signature of security personnel