



2125 South Neil Street
Champaign, IL 61820-7266
(217) 356-3736
www.womenshealthpractice.com

EMPLOYMENT APPLICATION

Date: _____

PERSONAL INFORMATION

Name: _____
First Middle Last

Address: _____

City/State/Zip: _____

How long at present address: _____

Phone Number: _____
Day Evening

Social Security Number: _____

Email Address: _____

Emergency Contact Person: _____

Phone Number Address

Have you ever been convicted of a felony? _____ If yes please explain the nature of the offense, number of convictions, sentences imposed, and rehabilitation:

Do you have a Driver's license? _____ If yes please provide number, state, and expiration date _____

EMPLOYMENT INTEREST

Position applying for: _____

Full Time Part Time

How many hours can you work weekly? _____ Are you available weekends and evenings?

Indicate Type of Experience:

Secretarial Typing _____wpm Shorthand _____wpm
 Customer Service Bookkeeping Collections
 Reception Filing Research
 Computer Skills/Programs (please list): _____

Nursing Phlebotomist/Lab Tech Certified Medical Assistant
 Certified Nursing Assistant Surgical Tech
 Other: _____

How soon are you available to start work? _____

How flexible is your vacation? _____

EDUCATION

High School: _____
Address: _____
City/State/Zip: _____
Dates Attended: _____ Date Graduated: _____

College: _____
Address: _____
City/State/Zip: _____
Dates Attended: _____ Date Graduated: _____

Other Special Training: _____
Address: _____
City/State/Zip: _____
Dates Attended: _____ Date Graduated: _____

LICENSURE

Registered Nurse Licensed Practical Nurse Other: _____

License Number: _____ State of Issue: _____
Date License Was Acquired/Issued: _____
Date License Was Effective or Renewed: _____
Date License Expires: _____

WORK EXPERIENCE (LIST MOST RECENT EMPLOYMENT FIRST)

MAY WE CONTACT YOUR CURRENT EMPLOYER? _____

Employer: _____
Title: _____
Address: _____
City/State/Zip: _____
Phone: _____
Dates of Employment: _____ Hours: _____
Reason for leaving: _____

Employer: _____
Title: _____
Address: _____
City/State/Zip: _____
Phone: _____
Dates of Employment: _____ Hours: _____
Reason for leaving: _____

Employer: _____
Title: _____
Address: _____
City/State/Zip: _____
Phone: _____
Dates of Employment: _____ Hours: _____
Reason for leaving: _____

OTHER INFORMATION

List other work experience: _____

Explain how you feel about voluntary termination of pregnancy: _____

Hobbies and interests: _____

Estimate the number of days taken annually due to illness: _____
Do we have permission to contact/speak with previous employers? Yes No

Expected starting salary: _____ Expected salary after one year: _____

Expected benefits: _____

If presently employed, why do you want to change jobs? _____

State why you want to be employed at Women's Health Practice? _____

Assess your: Verbal skills/abilities: _____
Skills in making financial arrangements: _____
Skills in expanded duties/responsibilities: _____
Skills in dealing with the public: _____

REFERENCES

Name: _____
Title: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Email Address: _____

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Email Address: _____

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COMMENTS

Signature

Date