EMPLOYMENT APPLICATION

Chest, Infectious Diseases and Critical Care Associates, P.C.
1601 NW 114th St., Suite 347
Des Moines, IA 50325-7046

CIC Associates, P.C. is an Equal Opportunity Employer. Federal & State law prohibit discrimination on the basis of race, religion, gender, age, disability, sexual orientation, national origin, genetic information or marital status. No question in this application is intended to elicit information in violation of any such law nor will any information obtained in response to any questions be used in violation of such law.	***Today's Date:*** ______________________________

Please complete this application in its entirety. Please do not indicate "See Resume". If the question is not applicable, please mark N/A.

Please Print

Full Name: ____

Street Address: ____

City/State: ____ Zip Code: ________________

Home #: ______________________ Cell #: _____________________ Business #: ______________

Position(s) Applied For:
____

How did you learn about this position?
____

Employment Type: ____Full-time ____Part-time ____PRN

Are you legally eligible to work in the U.S.A.? _________Yes _________No
(Proof of identity and eligibility will be required upon employment)

Are you over the age of 18 years? _________Yes _________No
(If no, you may be required to provide authorization to work)

Branch of Armed
Forces:_____________________________________From______________To______________

Have you ever been convicted of a felony or a misdemeanor which resulted in imprisonment within the last seven years? _______Yes ________No
(A conviction will not necessarily result in the denial of employment) If "Yes", please indicate the reason:
____
____
____
____
____
____
____

NAME OF SCHOOL	ADDRESS OF SCHOOL	Dates Attended	Diploma/Degree
High School__________________________	________________________	______________	_____________
Community College____________________	________________________	______________	_____________
College/University_____________________	________________________	______________	_____________
Other Education/Training________________	________________________	______________	_____________

License/Certification Held:	License Number:	Expiration Date:
____________________________________	________________________	______________

Have you completed any special courses, seminars and/or training that would enable you to perform the position for which you are applying? ________Yes _________ No
If yes, Please describe:

____
____
____
____

<u>THIS SECTION MUST BE FULLY COMPLETED EVEN IF YOU SUBMIT A RESUME</u>: List all previous employers, starting with your present or most recent position below. You may include any volunteer, intern or summer work experience.

Were you previously employed by CIC? _____Yes _____No

If "Yes", please indicate the following: Dates:________ Position:____

Supervisor's Name/Title:_______________________Dates of Employment:________________________________
FROM TO

Duties: ____

Position: _____________________________Starting Rate of Pay: ____________ Ending Rate of Pay: ___________

Reason for Leaving: ____

Employment: Please detail your employment history for the past 10 years.
Start with your present or most recent position.

Company: ____**Phone No:** ______________________________

Address: ____
Street City State Zip Code

Supervisor's Name/Title:_______________________Dates of Employment:_________________________________
FROM TO

Duties: ____

Position: ______________________________Starting Rate of Pay: ____________Ending Rate of Pay: ___________

Reason for Leaving: ____

Company: ____Phone No: _______________________________

Address: ____
Street City State Zip Code

Supervisor's Name/Title:__________________________Dates of Employment:______________________________
FROM TO

Duties: ____

Position: ______________________________Starting Rate of Pay: ____________Ending Rate of Pay: ___________

Reason for Leaving: ____

Company: ____Phone No: _______________________________

Address: ____
Street City State Zip Code

Supervisor's Name/Title:__________________________Dates of Employment:______________________________
FROM TO

Duties: ____

Position: ______________________________Starting Rate of Pay: ____________Ending Rate of Pay: ___________

Reason for Leaving: ____

Company: ____Phone No: _______________________________

Address: ____
Street City State Zip Code

Supervisor's Name/Title:__________________________Dates of Employment:______________________________
FROM TO

Duties: ____

Position: ______________________________Starting Rate of Pay: ____________Ending Rate of Pay: ___________

Reason for Leaving: ____

May we contact your present employer? ____Yes ____No May we contact past employers? ____Yes ____No

List references, other than former employers or relatives:

Name	Address	Occupation	Telephone

Read Carefully Before Signing: ***I certify the statements made above are true and I realize that falsification of information on this form, or any part of the interview process may be grounds for disqualification of my application or dismissal from employment.***
DATE: ________________________ ***SIGNATURE:*** ____

Thank you for completing this application for employment. You can be assured that our review of your job qualifications will be based solely on merit and a final determination will be reached as soon as possible.

Statement of Understanding

PLEASE READ AND INITIAL EACH PARAGRAPH BELOW. If there is any part of this you do not understand, please ask the interviewer about it before signing.

Investigation & Reference Check Consent to Release Information

_______*I authorize CIC Associates, P.C. to investigate any application information I have provided in order to verify its accuracy and elicit additional information as may be deemed necessary. By my signature below, I release prior employers, supervisors, personal references or other sources of information from all claims, liabilities or damages that may arise out of their supplying such information.*

______ *I understand that, should this investigation prove unsatisfactory, or if in the judgment of the company, false information, misrepresentation or omissions are discovered, any offer of employment may be withdrawn or, if I have already been hired, my employment may be terminated immediately without any obligation or liability to me, other than payment for services actually rendered.*

Criminal Record, Dependent Adult or Child Abuse Record

_______*I understand that CIC Associates, P.C. may conduct a criminal record check and dependent adult or child abuse record check on me. If a record is found, a through investigation and evaluation of the information will be made by the company and the Department of Human Services to determine whether employment is warranted. If it is determined that the records warrant prohibition of employment – employment shall be denied or terminated.*

Education and Licensure Verification

_______*I hereby grant permission to CIC Associates, P.C. to request and receive high school/GED records, college transcripts or records of graduation from my previous schools. I also authorize the verification of any educational requirements or licensure that is pertinent to the job.*

Job Application Records

_______*I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement on this application or on any documents used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.*

Proof of Identity

_______*I understand that if offered employment, I will, as a condition of employment, be required to submit proof of my identity and legal right to work in the United States on my first day of employment.*

Employment-At-Will

_______*I understand that nothing contained in the application or conveyed to me during any interview is intended to create an employment contract, implied or explicit, between CIC Associates, P.C. and me. I understand that an offer of employment does not constitute a contract for continued employment; employment with CIC Associates, P.C. is at-will and as such can be terminated with or without cause, with or without notice, at any time, at the option of either the company or myself. I agree that any policies or procedures published or distributed by CIC Associates, P.C. are for informational purposes only and are not intended to create any contractual rights. Such policies and procedures may be nullified or revoked by the company at any time, without prior notice.*

______*I understand that Mercy West Medical Center is a tobacco-free environment.*

My signature below certifies that I have read and understand the contents of this form, and agree to the terms and conditions outlined in this document.

___________________________________ ______________________________

Applicant's Signature Date

EMPLOYMENT REFERENCE CHECK

CONSENT TO RELEASE INFORMATION

I hereby authorize my present and former supervisor or employer to disclose to CIC Associates, P.C. any and all information with respect to my present or former employment for the purpose of pre-employment consideration. A photocopy of this authorization shall be considered as effective and valid as the original.
I authorize all references, professional and personal, to release the information requested to CIC Associates, P.C.

____ _________________________
Signature Date

Please list your references in order with your most recent first. Additional comments may be added on the back of this form.

Employer:_______________________	Name:_______________________
Address:_______________________	Title:_______________________
_______________________	**Phone #:**_______________________

Employer:_______________________	Name:_______________________
Address:_______________________	Title:_______________________
_______________________	**Phone #:**_______________________

Employer:_______________________	Name:_______________________
Address:_______________________	Title:_______________________
_______________________	**Phone #:**_______________________

Iowa Department of Human Services

Authorization for Release of Dependent Adult Abuse Information

This form must be used to authorize release of dependent adult abuse information when the person requesting the information does not have independent access to it in Iowa law. The purpose of the request for dependent adult abuse information is for employment purposes.

APPLICANT: Complete the boxes directly below. Please Print Legibly.

Name (first, middle initial, last)			
Maiden Name or Alias (mandatory, if applicable)	Birth Date	Social Security Number	
Address			
City	State	Zip Code	County

Criminal Penalties (235B.12)
1. Any person who willfully requests, or seeks to obtain dependent adult abuse information under false pretenses, or who willfully communicates or seeks to communicate dependent adult abuse information to any agency or person except in accordance with section 235B.6 and 235B.8, or any person connected with any research authorized pursuant to section 235B.6 who willfully falsifies dependent adult abuse information or any records relating thereto, is guilty of a serious misdemeanor. Any person who knowingly, but without criminal purposes, communicates or seeks to communicate dependent adult abuse information except in accordance with section
235B.6 and 235B.8 shall be guilty of a simple misdemeanor.

2. Any responsible grounds for belief that a person has violated any provision of this chapter shall be grounds for the immediate withdrawal of any authorized access such person might otherwise have to dependent adult abuse information.

Redissemination of Dependent Adult Abuse Information (235B.8)
1. A recipient of dependent adult abuse information authorized to receive the information shall not redisseminate the information, except that redissemination shall be permitted when all of the following conditions apply:
a. The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
b. The person to whom such information would be redissiminated would have independent access to the same information under section 235B.6.
c. A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
d. The written record is forwarded to the registry within thirty days of the redissemination.

I have read and understand the legal provisions for handling dependent adult abuse information that are printed on this page. I consent to release dependent adult information to CIC Associates, PC.

Applicant Signature ____________________________ **Date**____________________

Note: Information will be released only to people who have access to it under Iowa Code section 235B.6.

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK
Form C

TO: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
515-281-5138
515-242-6876 (fax)

FROM: **CIC Associates**
1601 NW 114th St. Ste. 347
Des Moines, IA 50325
Phone: 515-657-4746
Fax: 515-223-6312

APPLICANT: Complete two boxes directly below.

I am requesting an Iowa Criminal History Check on:

Print legibly

REQUEST

____________________	____________________	____________________	____________________
Last Name (Mandatory)	Maiden Name (Mandatory)	First Name (Mandatory)	Middle Name (Mandatory)

________/______________/____________	____________	______________________________
Date of Birth (Mandatory)	Sex (Mandatory)	Social Security Number (Mandatory)

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation.

Applicant
Signature____Date_____________________