

Brookland-Cayce Medical Practice 803-939-0174 Pediatrics of Batesburg/Leesville 803-532-2208
Brookland Community Pediatrics 803-739-6982 Ridgeway Family Practice 803-337-2920
Sterling Sharpe Pediatric Center 803-252-7001 Children's Dentistry at Ridgeway Family Practice
Waverly Family Practice 803-748-1181
Waverly Women's Health Center at Baptist 803-744-0540
Eau Claire Internal Medicine 803-754-0151 Administrative Offices 803-733-5969

Date of application: \_\_\_/\_\_\_/\_\_\_ Position(s) applied for: \_\_\_
Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the Human Resources Department.
PLEASE PRINT - USE INK ONLY

Name: \_\_\_ Social Security# \_\_\_
LAST FIRST MIDDLE

Address: \_\_\_
STREET APT# CITY ZIP CODE

Home Phone# (\_\_\_) \_\_\_ Work Phone (\_\_\_) \_\_\_
I WILL ACCEPT CALL AT WORK
PLEASE DO NOT CALL ME AT MY WORK NUMBER

Cell Phone#(\_\_\_) \_\_\_ Beeper#(\_\_\_) \_\_\_ Email: \_\_\_

Date available for work: \_\_\_/\_\_\_/\_\_\_ Your current salary: \$ \_\_\_ Desired salary range: \$ \_\_\_

Type of employment you are seeking: \_\_\_ Full Time \_\_\_ Part Time \_\_\_ Weekends \_\_\_ Days \_\_\_ Evenings
(Select all that apply)

Are you able to meet the attendance requirements of the position(s) you are applying for? \_\_\_ Yes \_\_\_ No (Select One)

If driving is required, give your Driver's License #: \_\_\_ State: \_\_\_

Are you under 18. If yes, do you have a work permit? Yes No
If not, why
Have you ever been employed by ECCHC. Yes No
If yes, when
Are you a US Citizen? Yes No
If not, what country
Are you legally eligible to work in this country? Yes No
Have you ever pled "guilty" or "no contest" to, or been convicted of a crime? Yes No
If yes, please give dates and explain.
Answering yes to this question does not automatically eliminate you from employment at ECCHC.

EMPLOYMENT HISTORY

Provide the following information of your past two (3) employer, assignments or volunteer activities. Start with your most recent employer.

CURRENT

From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Position/Title: \_\_\_
Employer Telephone# (\_\_\_) \_\_\_ May we contact for reference? (check one) \_\_\_ Yes \_\_\_ No
Address City State Zip Code
Brief Description of Work and Responsibilities
Hourly /Salary: Starting: \$ \_\_\_ Per Final: \$ \_\_\_ Per Supervisor: \_\_\_ Title: \_\_\_
Reason for leaving: \_\_\_

From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Position/Title: \_\_\_
Employer Telephone# (\_\_\_) \_\_\_ May we contact for reference? (check one) \_\_\_ Yes \_\_\_ No
Address City State Zip Code
Brief Description of Work and Responsibilities
Hourly /Salary: Starting: \$ \_\_\_ Per Final: \$ \_\_\_ Per Supervisor: \_\_\_ Title: \_\_\_
Reason for leaving: \_\_\_

From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Position/Title: \_\_\_
Employer Telephone# (\_\_\_) \_\_\_ May we contact for reference? (check one) \_\_\_ Yes \_\_\_ No
Address City State Zip Code
Brief Description of Work and Responsibilities
Hourly /Salary: Starting: \$ \_\_\_ Per Final: \$ \_\_\_ Per Supervisor: \_\_\_ Title: \_\_\_
Reason for leaving: \_\_\_

**Special /Related Training**

List any special training that you've completed that may qualify you as being able to perform job-related functions in the position for which you are applying:

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Comment on any additional related experience(s) you may have had that may qualify you as being able to perform job-related functions in the position for which you are applying. (For Example: Clinical Experience, Home Health Care, Urgent Care, Senior Care, Pharmacy, Voluntary Service, etc.):

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**REFERENCES**

Name	Telephone#	Number of years known
	( )	
	( )	
	( )	

**Job Related Education**

	NAME AND LOCATION	NUMBER OF YEARS COMPLETED	DID YOU GRADUATE?		COURSE OF STUDY
			MAJOR	DEGREE	
HIGH SCHOOL					
COLLEGE					
OTHER					

**License and Certification**

List all applicable licenses or certification that you have and their expiration dates below:

LICENSE/CERTIFICATION	# IF APPLICABLE	DATE ISSUED	EXP. DATE
LICENSE/CERTIFICATION	# IF APPLICABLE	DATE ISSUED	EXP. DATE
LICENSE/CERTIFICATION	# IF APPLICABLE	DATE ISSUED	EXP. DATE

**Applicant Statement**

I certify that all information I have provided in order to apply for and secure work with Eau Claire Cooperative Health Centers, Inc. (ECCHC) is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (1.) cancel further consideration of this application, or (2) immediately discharge me from ECCHC service, whenever it is discovered.

I expressly authorize, without reservation, ECCHC, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims I may have regarding ECCHC, its agents, employees or representatives, for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that ECCHC does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration from employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from ECCHC and still wish to be considered for employment, it will be necessary to reapply and fill out a new application.

I understand that South Carolina is an at-will state. This applications does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of ECCHC is authorized to make any assurances to the contrary and that no implied, oral or written agreement contrary to the foregoing express language are valid unless they are in writing and signed by the ECCHC's CEO.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

**DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANTS STATEMENT**

I certify that I have read, fully understand and accept all terms of the foregoing Applicant's Statement.

**Applicant's Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_