



"Your Vision Is Our Focus"

APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE

AN EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

NAME Last	First	Middle/Maiden	SOCIAL SECURITY NUMBER	
PRESENT ADDRESS		CITY	STATE	ZIP
PERMANENT ADDRESS		CITY	STATE	ZIP
ARE YOU 18 YEARS OR OLDER? ___ YES ___ NO		PHONE		

DESIRED EMPLOYMENT

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU CURRENTLY EMPLOYED?	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER?	
EVER APPLIED TO GRAYSTONE OPHTHALMOLOGY BEFORE? ___ YES ___ NO	WHERE?	WHEN?
EVER WORKED FOR GRAYSTONE OPHTHALMOLOGY BEFORE? ___ YES ___ NO	WHERE?	WHEN?
REASON FOR LEAVING		
NAME OF LAST SUPERVISOR AT GRAYSTONE OPHTHALMOLOGY		
WHO REFERRED YOU TO GRAYSTONE OPHTHALMOLOGY? ___ EMPLOYMENT AGENCY ___ NEWSPAPER ADVERTISMENT ___ FRIEND ___ WALK-IN ___ STATE EMPLOYMENT OFFICE ___ COLLEGE PLACEMENT SERVICE ___ OTHER (PLEASE SPECIFY) _____		

EDUCATION

SCHOOL LEVEL	NAME AND LOCATION OF SCHOOL	# YRS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK
SPECIAL TRAINING OR SKILLS

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PERSONAL INFORMATION

NAME Last	First	Middle/Maiden	SOCIAL SECURITY NUMBER
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FORMER EMPLOYERS

LIST BELOW YOUR LAST THREE EMPLOYERS, STARTING WITH THE MOST RECENT ONE FIRST

NAME OF PRESENT OR LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP CODE
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR? ___ YES ___ NO	
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP CODE
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR? ___ YES ___ NO	
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

NAME OF LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP CODE
STARTING DATE	LEAVING DATE	JOB TITLE	
WEEKLY STARTING SALARY	WEEKLY FINAL SALARY	MAY WE CONTACT YOUR SUPERVISOR? ___ YES ___ NO	
NAME OF SUPERVISOR	TITLE	PHONE	
DESCRIPTION OF WORK			
REASON FOR LEAVING			

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PERSONAL INFORMATION

NAME Last	First	Middle/Maiden	SOCIAL SECURITY NUMBER
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REFERENCES

GIVE THE NAMES OF THREE PERSONS YOU ARE NOT RELATED TO WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1.			
2.			
3.			

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ___ YES ___ NO
IF YES, EXPLAIN (WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION)

AUTHORIZATION

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release Graystone Ophthalmology Associates from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of Graystone Ophthalmology Associates has the authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized representative."

Date

Signature

DO NOT WRITE ON THIS PAGE FOR INTERVIEWER'S USE ONLY

PERSONAL INFORMATION

NAME Last	First	Middle/Maiden	SOCIAL SECURITY NUMBER
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INTERVIEWED BY	DATE
COMMENTS	

INTERVIEWED BY	DATE
COMMENTS	

INTERVIEWED BY	DATE
COMMENTS	

DATE HIRED	FOR DEPARTMENT AND POSITION	DATE OF BIRTH
SALARY/WAGES	ORIENTATION DATE	FIRST DAY OF WORK

APPROVED (SUPERVISOR)	DATE
APPROVED (PRACTICE MANAGER)	DATE
APPROVED (PHYSICIAN) (IF APPLICABLE)	DATE