



424 State Hwy 5 W
 Waconia MN 55387
 952-442-4461

Employment Application

We are an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including race, color, age, sex, religion, handicap, or national origin.

LAST NAME		FIRST NAME		MIDDLE NAME	
OTHER NAMES YOU HAVE USED TO IDENTIFY YOURSELF (FOR REFERENCE PURPOSE ONLY)					
CURRENT STREET MAILING ADDRESS:			CITY	STATE	ZIP CODE
PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE)					
HOME PHONE #:		OTHER NUMBERS WHERE YOU MAY BE CONTACTED		BEST TIME TO CONTACT YOU _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
HOW WERE YOU REFERRED TO OUR ORGANIZATION?		HAVE YOU BEEN EMPLOYED HERE BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Dates: From _____ To _____			
EVER APPLIED TO THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO When? _____		ARE YOU LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
POSITION DESIRED:			SALARY DESIRED:		
DATE AVAILABLE TO START WORK			Employment Interest: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		

Educational Record

School	Name & Location	Course of Study	Circle Year Completed	Did you graduate?	Certificate / Degree Received
High			1 2 3 4	yes / no	
Technical			1 2 3 4	yes / no	
College			1 2 3 4	yes / no	
College			1 2 3 4	yes / no	

EXTRACURRICULAR ACTIVITIES IN WHICH YOU PARTICIPATED - PLEASE INDICATE ANY OFFICES HELD***

***Applicant need not disclose any activities which might reveal them as a member of a protected class.*

Licenses and/or Certifications

Nurses, Medical Tech, X-ray Tech, etc.

Current Number _____ <input type="checkbox"/> License <input type="checkbox"/> Certificate <input type="checkbox"/> Registration	Occupation _____ Status Of License _____ Expiration Date _____ State Issued: _____ Date: _____
Other Qualifications -	Describe any training or qualifications (not previously covered) that might be of interest

Employment History

List Most Recent First

Company Name		From		To		Starting Salary	
						Ending Or Current Salary	
Job Title		City			State		
Supervisor's Name		Telephone Number		Reason For Leaving			May We Contact This Employer <input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact
Brief Job Description							
Company Name		From		To		Starting Salary	
						Ending Or Current Salary	
Job Title		City			State		
Supervisor's Name		Telephone Number		Reason For Leaving			May We Contact This Employer <input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact
Brief Job Description							
Company Name		From		To		Starting Salary	
						Ending Or Current Salary	
Job Title		City			State		
Supervisor's Name		Telephone Number		Reason For Leaving			May We Contact This Employer <input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact
Brief Job Description							
Company Name		From		To		Starting Salary	
						Ending Or Current Salary	
Job Title		City			State		
Supervisor's Name		Telephone Number		Reason For Leaving			May We Contact This Employer <input type="checkbox"/> Yes, Immediately <input type="checkbox"/> Yes, At a Later Date <input type="checkbox"/> No, Do Not Contact
Brief Job Description							

References

List 3 Professional References

Name	Relationship/Title	Address	Telephone

Applicants Statement

I certify that the facts set forth in this Application for Employment are true and complete to the best of my knowledge. I understand that if I am employed, false, misleading or omitted information may result in my dismissal. I authorize Lakeview Clinic, Ltd. to conduct an investigation of my previous employment and educational history, I agree to cooperate in the investigation and I authorize my former employers and references to disclose information regarding my former employment, character and general reputation to the Company, without giving me prior notice of such disclosure.

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be "at will" and without fixed term, and may be terminated at any time, with or without cause and without prior notice, at the option of either myself or the Company. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon the Company unless made in writing.

I understand that filling out this form does not indicate there is a position open and does not obligate the Company to hire. If hired, I agree to abide by all Company work rules, policies and procedures. The Company retains the right to revise its policies, in whole or in part, at any time.

I certify that I have read, fully understand and accept all terms as stated above.

Signature of Applicant: _____ Date: _____



Affirmative Action Questionnaire

In compliance with Local, State, and Federal Affirmative Action and Equal Employment regulations, Lakeview Clinic, Ltd., is responsible for developing a monitoring system to evaluate its selection and hiring practices, measure the effectiveness of its Affirmative Action Plan and produce required reports to various governmental agencies.

In order to comply with these regulations we need to identify certain applicant data. You are not required by law to provide the information requested.

If you elect to provide the information, it will be detached from your application and will not be used to make a decision about employment.

General Information:

Name _____ Telephone # _____

Address _____

Male _____	Female _____	American Indian or Alaskan Native	_____
		Native Hawaiian or Pacific Islander	_____
		Caucasian	_____
		Asian	_____
		Hispanic or Latino	_____
		Black or African American	_____
		Two or more of the above races	_____
		Do Not Wish To Identify	_____

Lakeview Clinic, Ltd. is required to take affirmative action to provide equal employment opportunities to qualified individuals belonging to certain groups listed below. Lakeview Clinic, Ltd. invites all qualified handicapped person, disabled veterans and veterans of the Vietnam Era to self-identify. This information is voluntarily provided and will be kept confidential and used only in accordance with Government Regulation and Lakeview Clinic, Ltd.'s Affirmative Action policy. Refusal to provide this information will not adversely affect consideration for employment. If you believe you are covered by these regulations and wish to receive consideration under them, please complete the following sections as applicable:

Handicapped: _____

“Handicapped” is defined as a person who:

1. Has physical or mental impairment, which materially limits a major life activity.
2. Has record of such impairment.
3. Is regarded as having such impairment.

List handicapping condition: _____

Veterans: _____ Disabled Veteran (Person entitled to VA Disability compensation or discharged from active duty for disability)

_____ Vietnam Era Veterans (served in military service anytime during 8/5/64 – 5/7/75)

Lakeview Clinic, Ltd.'s Affirmative Action Plan is available for viewing in the Administrative Offices of Lakeview Clinic, Ltd.

Office Use Only: Position _____ I: _____ H: _____

