

Application for Employment

UBMD Family Medicine and UBMD Internal Medicine are Equal Employment Opportunity (EEO) and Affirmative Action Employers committed to excellence through diversity. Employment offers are made on the basis of qualifications and without regard to race, sex, religion, national or ethnic origin, disability, age, veteran status or sexual orientation.

PLEASE TYPE OR PRINT Complete the entire application. **Even if you are submitting a resume, you must still complete ALL questions or your application will be deemed incomplete and may not be considered.** When completed, please either email your application and resume to hr@ubmdim.com, or fax to (716) 961-9910.

NAME:

DATE OF APPLICATION:

POSITION APPLYING FOR:

HOME PHONE:

STREET ADDRESS:

PRACTICE PLAN APPLYING TO:

UBMD FAMILY MEDICINE

UBMD INTERNAL MEDICINE

CITY, STATE, ZIP CODE:

EMAIL:

CELL PHONE:

| | | | |
|--|------------------------------|-----------------|---|
| | | | |
| Are you eligible to work in the United States? | Yes | No | |
| Can you, upon employment, provide genuine documentation establishing your identity and eligibility to be legally employed in the US? | Yes | No | |
| Are you 18 years of age or older? | Yes | No | If NO, what is your current age? |
| Have you ever been employed by UBMD Internal Medicine? | Yes | No | If YES, dates of employment & reason for leaving: |
| Are you related to any current UBMD Internal Medicine Employee? | Yes | No | If YES, their name & their relationship to you? |
| How did you learn about this employment opportunity? Check all that apply: | | | |
| Website | Referral by employee – Name: | Ad in newspaper | Job Bulletin (Posting) |
| | | Other: | |
| Have you ever been discharged from any employer or asked to resign? | Yes | No | If YES, please explain: |

MANDATORY FIELD - Please indicate wage expected with dollars only.

WAGE EXPECTED:

Hour

Year

DATE AVAILABLE TO START:

WORK EXPERIENCE

Please detail your entire work history. Begin with your current or most recent employer. If you held multiple positions with the same organization, detail each position separately. Attach additional sheets if necessary. Omission of prior employment may be considered falsification of information. Please explain any gaps in employment. Include full-time military or volunteer commitments.

PLEASE NOTE: UBMD Family Medicine and UBMD Internal Medicine reserve the right to contact all current and former employers for reference information.

Start with present/last employer:

| | | | | |
|--|--------------------------------|-------------------------|------------------|--------------------------------|
| DATES EMPLOYED: | | Full-time | Part-time | TITLE: |
| From: | To: | If part-time, # hrs/wk: | | |
| COMPANY NAME: | | | PHONE: | |
| ADDRESS (Street, City, State, Zip Code): | | | | |
| SUPERVISOR'S NAME: | | | STARTING SALARY: | |
| TITLE: | | | ENDING SALARY: | |
| PHONE: | Contact my current references: | | At any time | Only if I am a final candidate |
| REASON FOR LEAVING: | | | | |
| | | | | |
| DATES EMPLOYED: | | Full-time | Part-time | TITLE: |
| From: | To: | If part-time, # hrs/wk: | | |
| COMPANY NAME: | | | PHONE: | |
| ADDRESS (Street, City, State, Zip Code): | | | | |
| SUPERVISOR'S NAME: | | | STARTING SALARY: | |
| TITLE: | | | ENDING SALARY: | |
| PHONE: | Contact my current references: | | At any time | Only if I am a final candidate |
| REASON FOR LEAVING: | | | | |
| | | | | |
| DATES EMPLOYED: | | Full-time | Part-time | TITLE: |
| From: | To: | If part-time, # hrs/wk: | | |
| COMPANY NAME: | | | PHONE: | |
| ADDRESS (Street, City, State, Zip Code): | | | | |
| SUPERVISOR'S NAME: | | | STARTING SALARY: | |
| TITLE: | | | ENDING SALARY: | |
| PHONE: | Contact my current references: | | At any time | Only if I am a final candidate |
| REASON FOR LEAVING: | | | | |
| | | | | |
| DATES EMPLOYED: | | Full-time | Part-time | TITLE: |
| From: | To: | If part-time, # hrs/wk: | | |
| COMPANY NAME: | | | PHONE: | |
| ADDRESS (Street, City, State, Zip Code): | | | | |
| SUPERVISOR'S NAME: | | | STARTING SALARY: | |
| TITLE: | | | ENDING SALARY: | |
| PHONE: | Contact my current references: | | At any time | Only if I am a final candidate |
| REASON FOR LEAVING: | | | | |
| | | | | |

EDUCATION

| NAME OF SCHOOL | CITY/STATE | # OF YEARS COMPLETED | DIPLOMA | GED | DEGREE RECEIVED | MAJOR |
|----------------------------|------------|----------------------|-----------|-----------|-----------------|-------|
| High School: | | 1 2 3 4 | Yes No | Yes No | | |
| College: | | Attended Yes No | | | | |
| Graduate School: | | Attended Yes No | | | | |
| Business/ Trade School: | | Attended Yes No | | | | |

SKILLS

Please list technical skills, clerical skills, trade skills, etc., relevant to this position. Include relevant computer systems and software packages which you have a working knowledge of and note your level of proficiency (basic, intermediate, expert).

REFERENCES

| NAME | COMPANY/TITLE | PHONE | EMAIL | YEARS KNOWN | MAY WE CONTACT |
|------|---------------|-------|-------|-------------|----------------|
| | | | | | Yes No |
| | | | | | Yes No |
| | | | | | Yes No |

A MEMBER OF



UB|MD
PHYSICIANS' GROUP



NOTIFICATION & AGREEMENT: PLEASE READ BEFORE SIGNING.

I CERTIFY THAT ALL ANSWERS GIVEN BY ME ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT THE FALSIFICATION, MISREPRESENTATION OR OMISSION OF FACT ON THIS APPLICATION (OR ANY OTHER ACCOMPANYING OR REQUIRED DOCUMENTS) WILL BE CAUSE FOR DENIAL OR EMPLOYMENT OR IMMEDIATE TERMINATION OF EMPLOYEMENT, REGARDLESS OF WHEN OR HOW DISCOVERED.

Questions regarding this statement should be directed to any employment interviewer before signing. The application will be given every consideration, but its receipt does not imply that the applicant will be employed.

It is the policy of the company to afford equal opportunity to all employees and applicants for employment without regard to age, race, religion, color, sex, national origin, marital status, expunged juvenile records or pregnancy and to afford equal opportunities to disabled veterans, military veterans of any era and individuals with a disability, and other characteristic protected by Federal, State or Local law.

I authorize the investigation of all statements and information contained in this application. I release from all liability anyone supplying such information and I also release the employer from all liability that might result from making an investigation.

If hired, I agree to abide by all of the company rules and regulations, and understand that, if employed, my employment may be terminated with or without cause, at any time, at the option of either the company or me. I further understand that no representation, whether oral or written by any representative or agency of the company, at any time, can constitute a contract of employment. I understand that the company and all plan administrators shall have the maximum discretion permitted by law to administer, interpret, modify, discontinue, enhance or otherwise change all policies, procedures, benefits or other terms or conditions of employment. No representative or agent of the company, has the authority to enter into any agreement for employment for any specified period of time or to make any change in any policy, procedure, benefit or other term or condition of employment other than in a document signed by Senior Administration or Human Resources, or to make any agreement contrary to the forgoing.

I acknowledge that I have read and understand the above statements and hereby grant permission to confirm the information supplied on this application by me.

APPLICANT SIGNATURE

DATE

If you are submitting electronically, please type your name on the form and select the box below.

I acknowledge and verify that this is an electronic signature, if this form is transmitted through electronic means.

Equal Opportunity, Affirmative Action Voluntary Self-Identification Form

NAME:

DATE:

POSITION APPLYING FOR:

PRACTICE PLAN APPLYING TO:

UBMD FAMILY MEDICINE

UBMD INTERNAL MEDICINE

UBMD Internal Medicine is an Equal Opportunity and Affirmative Action Employer. As required by law, we must record certain information to be made a part of our Affirmative Action Program. Applicants for employment are invited to participate in the Affirmative Action Program by reporting their status as disabled, disabled veteran, veteran of the Vietnam era or other minority. In extending this invitation, you are also advised that: (a) workers (applicants) are under no obligation to respond, but may do so in the future if they choose; (b) responses will remain confidential within the Human Resources Department; and (c) responses will be used only for the necessary data required for our Equal Opportunity Reporting and Affirmative Action Program. We are a company that values diversity. Refusal to provide this information will not have a bearing on your potential employment or employment status and will not subject you in any adverse treatment.

1. Race (select one)

White (Not Hispanic or Latino) - a person having origins in any of the original peoples of Europe, North America and the Middle East.

Black or African American (Not Hispanic or Latino) - a person having origins in any of the black racial groups of Africa.

Hispanic or Latino - all persons of Cuban, Mexican, Puerto Rican, South or Central American or any other Spanish culture or origin regardless of race.

Asian - a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or Other Pacific Islander - a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

American Indian/Alaskan Native - all persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

Two or More Races - all persons who identify with more than one of the above races.

2. Gender Male Female

3. Veteran Status

Are you a veteran? No Yes - Separation Date from Military: Date/Time Field

Disabled Veteran - a veteran who (1) is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans' Affairs for a disability; or (2) was discharged or released from active duty because of a service-connected disability.

Other Protected Veteran - a person who served on active duty during a war (other than the Vietnam War) or in a campaign or expedition for which a campaign badge has been authorized. To identify the campaigns or expeditions that meet this criterion, please consult the VETS-100 website (<http://www.fedshirevets.gov/hire/hrp/vetguide/index.aspx>).

Armed Forces Service Medal Veteran - a person who, while serving on active duty in the US military, ground, naval or air service, participated in a United States military operation for which an Armed Forces Service Medal was awarded pursuant to Executive Order 12985.

Recently Separated Veteran - a veteran who was discharged or released from active duty within the last three (3) years.

4. Disability Status

Individual with a Disability - a person who (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such impairment; or (3) is regarded as having such impairment.

5. I DO NOT WISH TO SELF-IDENTIFY

If you are submitting electronically, please type your name on the form and select the box below.

I acknowledge and verify that this is an electronic signature, if this form is transmitted through electronic means.

 Signed By