



3305 South 20<sup>th</sup> Street, Suite 150  
 Milwaukee, Wisconsin 53215  
 Phone: 414-384-2100  
 Fax: 414-384-2700  
 Email: hr@wiasc.com

## WISCONSIN SURGERY CENTER APPLICATION FOR EMPLOYMENT

**PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE**

**PLEASE COMPLETE ALL PAGES**

DATE \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Maiden

Present address \_\_\_\_\_  
Number Street City State Zip

Daytime Telephone ( ) \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Evening Telephone ( ) \_\_\_\_\_ Have you ever applied at this company before?  Yes  No

Are you at least 18 years old?  Yes  No (If not, your employment will be subject to verification that you meet state/federal minimum age requirements for the type of work you are applying for and have obtained a valid work permit.)

Position applied for (1) \_\_\_\_\_  
 and salary desired (2) \_\_\_\_\_  
 (Be specific)

Days/hours available to work  
 No Pref \_\_\_\_\_ Thur \_\_\_\_\_  
 Mon \_\_\_\_\_ Fri \_\_\_\_\_  
 Tue \_\_\_\_\_ Sat \_\_\_\_\_  
 Wed \_\_\_\_\_ Sun \_\_\_\_\_

How many hours can you work weekly? \_\_\_\_\_ Employment desired:  Full-time  Part-time  Temporary/Seasonal

When available for work? \_\_\_\_\_ How were you referred to the company? \_\_\_\_\_

Are you legally authorized to work in the U.S.?  Yes  No (If hired, you will be required to provide proof of work authorization.)

Are there other names under which you have worked or attended school?  Yes  No (Please list for reference-checking purposes.)

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. or Trade School				
Professional School				

Have you ever been convicted of a crime, other than a minor traffic violation?  Yes  No If yes, please explain: \_\_\_\_\_

Convictions are not an absolute bar to employment but will be considered in relationship to the job requirements



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If required to drive a motor vehicle for the job applying for, do you have a valid driver's license?  Yes  No

What is your means of transportation to work? \_\_\_\_\_

Driver's license number \_\_\_\_\_ State of issue \_\_\_\_\_  Operator  Commercial (CDL)  Chauffeur  
 Expiration date \_\_\_\_\_

Have you had any accidents during the past three years? \_\_\_\_\_ How many? \_\_\_\_\_

Have you had any moving violations during the past three years? \_\_\_\_\_ How Many? \_\_\_\_\_

**PROFESSIONAL LICENSES AND/OR CERTIFICATIONS**

Are you currently:  Registered  Licensed  Certified

Are you eligible for:  Registration  Licensure  Certification

**If licensed, registered or certified:**

TYPE:	NUMBER:	STATE ISSUED:	DATE ISSUED:	EXPIRATION DATE:

Has your license/certification/registration ever been revoked or suspended?  Yes  No

If yes, state reason(s), date of revocation or suspension, and date of reinstatement: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list two references other than relatives or previous employers.

Name _____	Name _____
Position _____	Position _____
Company _____	Company _____
Address _____	Address _____
_____	_____
Telephone (____) _____	Telephone (____) _____

List any foreign languages you write, speak, or understand: \_\_\_\_\_

Are you able to perform all of the duties of the desired position?  Yes  No If no, describe the functions that can not be performed: \_\_\_\_\_

Do you have any friends or relatives working for Advanced Pain Management?  Yes  No

If yes, state names(s) and relationship(s) \_\_\_\_\_

An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications for the specific position for which you are applying.



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**Education & Continuing/Training Education** Please list any relevant training courses or continuing education programs completed.

Name and Address of School	Date(s) Attended	Course or Major	Diploma/Degree

**Work experience** Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name of employer Address City, State, Zip Code Phone number	Name of Supervisor	Employment Dates	Pay/Hour or Salary
			From To
Job Title			

Reason for leaving (be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

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Name of employer Address City, State, Zip Code Phone number	<b>Name of Supervisor</b>	<b>Employment Dates</b>	<b>Pay/Hour or Salary</b>
		From	Start
		To	Final
Job title			

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		From	Start
		To	Final
Job title			

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**PERSON TO BE NOTIFIED IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Relationship \_\_\_\_\_

May we contact your present employer?  Yes  No

Did you complete this application yourself?  Yes  No

If not, who did? \_\_\_\_\_



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**PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM**

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1. All information contained in this application is true and correct to the best of my knowledge and belief. I understand that misrepresentations or omissions of any kind may result in denial of employment or be cause for subsequent dismissal if I am hired.
2. I authorize the Wisconsin Surgery Center to investigate my responses on this application and contact any or all of my former employers or any individuals familiar with me or my employment background for the purpose of verifying any information I have provided and/or for the purpose of obtaining any information, whether favorable or unfavorable, about me or my employment. I voluntarily and knowingly fully release and hold harmless any person or organization that provides information pertaining to me or my employment.
3. Regardless of whether or not I become employed by the company, I recognize that this application is not and should not be considered a contract of employment. I understand that employment at the company is on an at-will basis and that my employment may be terminated with or without cause, and without notice, at any time, at my option or the company's, unless specifically provided otherwise in a written employment contract. I further understand that no company employee or representative has the authority to enter into a contract regarding duration or terms and conditions of employment other than an officer or official of the company, and then only by means of a signed, written document.

**Signature of applicant** \_\_\_\_\_ **Date:** \_\_\_\_\_

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This Company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with Advanced Pain Management depends solely on your qualifications.

*Thank you for completing this application form and for your interest in our business.*