Joan M. Kanter, DDS, PA, 5076 Dorsey Hall Drive, Ellicott City, MD 21042 410-715-9555

Date:_____

APPLICATION FOR EMPLOYMENT

In order that your application may be properly evaluated, it is essential that you answer all questions carefully and completely. You will be considered without regard to your race, creed, sex, religion, marital status, national origin, or age.

PLEASE PRINT

Name in full: _____

Present address: _____

Permanent address: _____

Daytime phone numbers: _____ Evening phone:_____

Position desired: _____ Salary expected: _____ Are you employed? _____

Where? _____ May we contact your present employer? _____

Date available to begin work: _____ Are you willing to be bonded? _____

What days and times are you available to work? _____

Work related injuries or chronic illness: _____

Can you work overtime? _____

Can you type? _____ Speed: _____ What computer experience do you have?_____

_____

Do you have experience with insurance processing? ____ Scheduling? ____ Dental terminology? ___
What other office skill do you have? _____

Circle the following items if you have experience with them: Dental Charting, CPR training, HIPPA regulations, OSHA sterilization requirements, four-handed assisting, x-ray processing, model pouring, oral hygiene instruction, other.
What certifications or licenses do you currently have?_____

EDUCATION

	Name	Did you graduate?	Year	Degree/Major	Attended from-to
High school					
College					
Other					

EMPLOYMENT (Please list starting with most recent employer)

	Present Employer	Previous Employer	Previous Employer
Company Name			
Address			
Phone number			
Immediate Supervisor			
Dates of Employment			
Salary			
Duties			
Reason for leaving			

REFERENCES (Please provide 3 references you have worked for in a professional capacity)

Name	Address	Professional Relationship/Business	Telephone Number
1.			
2.			
3.			

READ CAREFULLY BEFORE SIGNING

1. The information given on this application is accurate and is subject to verification. I understand that furnishing any misleading or incorrect information will render this application void and will be just cause for immediate termination in the event of my employment. In consideration of my employment, I agree to conform to the employer's rules and regulations and agree that my employment and compensation may be terminated, with or without cause, and with or without notice, at any time, at the option of the employer.
2. I hereby grant permission to contact any persons, companies, school or health care providers named or referred to in this application, and I hereby authorize those persons, companies, schools, or health care providers to provide my records, my reason for leaving and all other information they have concerning me.
3. I further release all such parties and the employer from any and all liability or claims for damage whatsoever that may result from such contact or information.
3. Should I desire to leave your employ, I agree to give my written resignation.
4. At no time, whether I am an employee or not, will any information regarding patients be revealed to anyone unless I have been specifically instructed to do so.
5. I agree to an annual physical exam, if required.

Date: _____Signature:

TO BE COMPLETED ON THE DATE EMPLOYMENT BEGINS

Date of Birth: _____ Social Security Number: _____ # of Dependents:

Marital Status: single married divorced widowed Do you need health insurance? Yes No