



APPLICATION FOR EMPLOYMENT

(PLEASE PRINT REQUESTED INFORMATION IN INK)

Date _____

This facility receives applications and employs persons without regard to race, color, sex, religion, age, national origin, physical or mental disability, marital status, veteran's status, citizenship status or any other category protected by local, state or federal law. In addition, this facility makes reasonable accommodation to the needs of disable applicants and employees, so long as this does not create an undue hardship on the surgical center or threaten the health or safety of others at work. The receipt of this application does not mean that job openings exist at our surgery center and does not obligate us in any way. We appreciate your interest in our facility.

PERSONAL INFORMATION

NAME: _____ SOCIAL SECURITY NO.: _____
Last First Middle

ADDRESS: _____ TELEPHONE NO.: _____
Street City State Zip

If hired, can you furnish proof of age? Yes No

If hired, can you furnish proof that you are legally entitled to work in the U.S.? Yes No

Have you ever been employed by the Ambulatory Surgery Center of WNY? Yes No
 If yes, please indicate dates of employment: _____ Position: _____

Can you perform the essential functions of the job, with or without reasonable accommodation? Yes No

AVAILABILITY

I am applying for the following position: _____ Date available for work: _____

Type of employment desired: Full-Time Part-Time Temporary

If applying for part-time employment, please indicate the hours and days you are available to work: _____

Would you consider working Weekends & Holidays Rotating Shifts On Call Any Shift

MISCELLANEOUS

Have you ever been convicted of a felony? Yes No

If yes, please explain (Such a conviction may be relevant if job related, but does not necessarily bar you from employment.)

EDUCATION

Schools Attended (include current)	City – State	Years Completed	Diploma/Degree
High School			
College or University			
Other			

Scholastic Honors, Scholarships, etc.

Ambulatory Surgery Center of Western New York
 945 Sweet Home Road
 Amherst, New York 14226
 (716)831-9435

Do you have any other experience, training, qualifications, or skills which would apply to the position for which you are applying?
Please list:

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

Type	State Issued	Date	Number
Type	State Issued	Date	Number
Type	State Issued	Date	Number

EMPLOYMENT HISTORY

Please list your employment record, including any periods of unemployment. Begin with your most recent employer. If you were employed under another name, please enter under the company name. Attach a resume only to supplement the information below. This application form must be completely filled out.

Company Name	Company Address	Telephone ()
Name of Supervisor	Employed (Month and Year) From To	Reason for leaving
State job title, nature of work and job responsibilities		May we contact this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Company Name	Company Address	Telephone ()
Name of Supervisor	Employed (Month and Year) From To	Reason for leaving
State job title, nature of work and job responsibilities		May we contact this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Company Name	Company Address	Telephone ()
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REFERENCES

List business or educational references of three non-relatives who are qualified to evaluate your education or work experience.

Name:	Address:	Position:	Telephone No.

I hereby state that the information given by me in this application is true in all respects. I understand that any material misrepresentation or deliberate omission of fact in my application may be justification for refusal of employment, or if employed, cause me to be subject to dismissal without notice at any time.

I understand that employment at the surgery center is on an at will basis and that employment is not offered, contracted or guaranteed for any specific period of time. I understand that employment may be terminated by either party at any time, with or without cause, and with or without notice.

I agree to search of my person or of any locker or property assigned to me, and hereby waive all claims for damages on account of such examination.

I authorize any physician or hospital to release any information which may be necessary to determine my ability to perform the duties of a job I am being considered for prior to employment, related papers, or oral interviews. I authorize such investigation and the giving and receiving of any information requested by this ASC and I release from liability any person giving or receiving such information.

I understand that this is an application for employment and that no employment contract is being offered.

I understand that if I am employed, such employment is for an indefinite period of time and that this ASC can change wages, benefits and conditions at any time.

A basic part of medical ethics is that all information concerning patients (their conditions, treatment and financial information), their doctors and your fellow employees, as well as personal information concerning bonuses and/or pay raises remain strictly confidential, any violation of confidentiality could result in discharge.

I have read, understand, and agree to the above.

Applicant's Signature _____ Date _____

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