

EMPLOYMENT APPLICATION

TWIN LAKES MEDICAL FOUNDATION LOGO

910 Wallace Avenue Leitchfield, Kentucky 42754

Equal Opportunity Employer  
Smoke and Drug Free Workplace

APPLICATIONS SHOULD BE SENT TO CENTRAL OFFICES' ATTENTION

Last Name	First Name	Middle	Date:
			Apps remain active for 6 months
Social Security Number: _____ Used for applicant tracking and reference checking			
List other names by which you have been employed:			
Please list telephone number(s) we can reach you or leave a message at (PLEASE DO NOT RELY ON CALLER ID):			
Present Address			
Have you ever been in our employ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Position:	Supervisor:	Dates:	
Please List relatives or friends employed by this facility			
How were you referred to this facility? <input type="checkbox"/> Website <input type="checkbox"/> Walk-In <input type="checkbox"/> Newspaper <input type="checkbox"/> Employee <input type="checkbox"/> Other _____			
Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, list Date of Birth: _____			
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you legally authorized to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been convicted of a crime? Applicants are not obliged to disclose sealed or expunged records of conviction, <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes; Explain: _____ Answering "Yes" does not automatically disqualify you from employment.			

EMPLOYMENT INFORMATION

Position(s) Applied For:		
Do you wish to be considered for positions other than the one(s) listed should one become available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Salary Desired	Date Available for Work	Shift (check all that apply) <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup>
Indicate Days Available (check all that apply) : <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri		
Are you willing to work (check all that apply) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> PRN (as needed)		
Are you willing to work if needed (check all that apply) <input type="checkbox"/> Weekends <input type="checkbox"/> Holidays <input type="checkbox"/> Call Rotation <input type="checkbox"/> Rotating Shifts <input type="checkbox"/> Rotating Weekends <input type="checkbox"/> Rotating Holidays		

**EDUCATION/SKILLS**

School	Name City and State	Course Concentration	Last Year Completed	Did you Graduate	List Diploma, GED Degree or Certification
High			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other			1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Workshops, Courses (include Military Training, HOSA, Post-Graduate and Nursing)

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Skills/Equipment Familiarity (Check all that Apply)

Word Processing     Spreadsheets     Internet/Email     10-key Punching  
 Blood Pressure     Telemetry     Copier/Fax     Medical Coding  
 Computerized Medical Documentation     Medical Terminology  
 CPR Expiration Date \_\_\_\_\_     PALS Expiration Date \_\_\_\_\_  
 ACLS Expiration Date \_\_\_\_\_

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Professional Licenses and/or Certifications

Type:	State Issued:	Expiration:	Number:
Type:	State Issued:	Expiration:	Number:
Type:	State Issued:	Expiration:	Number:
Type:	State Issued:	Expiration:	Number:

**TLMF Use Only**

Receive Date:	Initial:	Letter Sent: <input type="checkbox"/> Yes # _____ <input type="checkbox"/> No
Reviewed by and Date:	Reviewed by and Date:	
Reviewed by and Date:	Reviewed by and Date:	
Interviewed by and Date:	Position:	
Interviewed by and Date:	Position:	
Interviewed by and Date:	Position:	

Comments:

Employment History: Begin with your PRESENT or MOST RECENT EMPLOYER and follow with former places of employment, including U.S. Military Service, temporary, seasonal, private, and all other employment. Complete information with as much detail as possible.

Job Title	Employed From	To	Last Salary	Per
Employer	Supervisor		Phone Number	
Address				
Duties				
Reason for Leaving				
May we contact for reference <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later				

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Reason for Leaving				
May we contact for reference <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later				

**YOU MAY ATTACH A RESUME TO THIS APPLICATION.**

APPLICANT STATEMENT: PLEASE READ CAREFULLY

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 on my application/resume may be justification for refusal of employment or if employed cause me to be subject to dismissal without notice at any time.

I agree that, by being an employee at will, my employment may be terminated by **Twin Lakes Medical Foundation (TLMF)** at any time, with or without good cause, without liability for wages or salary except that earned at the date of termination. I understand this is an application for employment and that no employment contract is being offered. I understand if employed, such employment is for an indefinite period of time and **TLMF** can change wages, benefits and conditions at any time.

I agree to a search of my person or of any 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 position for which I am being considered prior to employment or in the future during my employment. I agree to submit to a health assessment including drug testing as a condition precedent to my employment, and I understand if I refuse to submit to this assessment, the conditional offer of employment may be revoked. I acknowledge that this health assessment is not a substitute for a comprehensive examination by a private physician.

I understand that business needs may make the following conditions mandatory: overtime, shift work, a rotating work schedule, or a work schedule other than Monday through Friday. I understand and accept these conditions of my continuing employment.

It is my understanding that **TLMF** may make a thorough investigation of my entire work and personal history and may verify all data given in my application for employment, related papers or oral information. I authorize such investigation and the giving and receiving of any information requested by **TLMF**, and I release from liability any person giving or receiving such information. I also understand if I am hired, I will be required to provide proof of identity and legal authorization to work in the United States and that Federal Immigration Laws require me to complete an I-9 form in that regard.

Do not sign until you have read the above applicant statement. I certify that I have read, fully understand, and accept all terms of the above.

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Date

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Applicants Signature

**Twin Lakes Medical Foundation** offers Equal Employment Opportunities to all persons without regard to race, religion, age, sex, national origin, disability, veteran status, citizen status, and all other protected groups. No question on this application is intended to secure information to be used for such discrimination. The use of this form does not mean there are positions open and does not obligate us in any way. Your employment application remains active for six months. You must reapply if you wish to be considered for employment beyond this period of time.

## EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION STATISTICS

**Twin Lakes Medical Foundation** is an  
Equal Employment Opportunity Employer

The information below is required by state and federal regulations for statistical and affirmative action purposes and does not influence employment decisions. Your voluntary anonymous responses will help us monitor our hiring practices to ensure compliance. This page is separated from your application immediately upon being received, and will be kept confidential. This form is to be completed voluntarily and failure to do so will not have an effect on the application process.

**Decline Self Identification: If you do not wish to self identify your gender, ethnicity or race please check the box**  I do not wish to self identify

**Sex: (please check one):**

Male       Female

**Ethnic Group: (please check one):**

Hispanic or Latino

White

Black or African American

Native Hawaiian or Other Pacific Islander

Asian

American Indian or Alaskan Native

Two or More Races (Not Hispanic or Latino) – all persons who identify with more than one of the above races

**Thank you!**

**This information is submitted voluntarily, will be kept confidential,  
will be exclusively utilized for EEO statistical gathering and compliance purposes,  
and will not influence the application or hiring process.**