

**Lowcountry Medical Group**  
LLC

**APPLICATION FOR EMPLOYMENT**  
**2010**

**Name of Applicant:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_  
Please Print

<b>PERSONAL INFORMATION</b>			
Last Name	First Name	Middle Initial	Today's Date
Street Address			Home Phone
City	State	Zip Code	Social Security Number
Position Desired			
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time _____ Hours per week	Shift Preference <input type="checkbox"/> Days <input type="checkbox"/> Evenings	Salary Desired \$ _____	Date you are available to start work: _____
Have you ever been convicted, pled guilty or no contest to a misdemeanor or a felony? Omit minor traffic violations. (Please note: A history of conviction(s) will not necessarily bar employment, and factors such as age and time of the offense, seriousness and nature of the violation, and rehabilitation will be taken into account.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates and explain below:			
Are you legally authorized to work in the U.S.? Proof will be required. <input type="checkbox"/> Yes <input type="checkbox"/> No Are you 18 years of age or over? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will you relocate? <input type="checkbox"/> Yes <input type="checkbox"/> No Willing to travel? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Source of Referral: <input type="checkbox"/> Advertisement <input type="checkbox"/> Agency/Search Firm <input type="checkbox"/> Job Fair/Open House <input type="checkbox"/> Employee Referral: <input type="checkbox"/> Friend <input type="checkbox"/> College Relations <input type="checkbox"/> Other _____ Name _____			
<b>EDUCATION</b>			
Name and location of high school		Diploma or equivalent received	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and location of college or university		Degree	GPA
Name and location of college or university		Degree	GPA
Name and location of college or university		Degree	GPA
Business, Technical/Vocational, Correspondence, etc.		Certificate or # of credits	Subject
Describe any other specialized training or qualifications relating to this position (such as seminars, military, professional affiliations, certificates or awards)			
List professional licenses/certificates		Expiration date	
<b>BUSINESS EQUIPMENT AND SKILLS</b>			
<u>Equipment Operated</u>		<u>Business Skills</u>	
<input type="checkbox"/> Calculator	<input type="checkbox"/> Word Processor	<input type="checkbox"/> 10 Key by Touch	<input type="checkbox"/> Programming Languages
<input type="checkbox"/> Computer Terminal (CRT)	<input type="checkbox"/> Other _____	<input type="checkbox"/> Data Entry Speed	<input type="checkbox"/> Accounting/Bookkeeping
<input type="checkbox"/> Personal Computer		<input type="checkbox"/> Typing _____ wpm	<input type="checkbox"/> Medical Terminology
<input type="checkbox"/> Software		<input type="checkbox"/> Dictaphone	<input type="checkbox"/> Other _____
<b>REFERENCES</b>			
Please list business or work related references and their relationship to you. Providing this information means that you give LCMG permission to contact the references listed.			
Name	Business Relationship	Telephone number	
1. _____	_____	_____	
2. _____	_____	_____	
3. _____	_____	_____	

**EMPLOYMENT RECORD****Instructions:**

- Please complete the following information in full. Do not use resume in lieu of information requested on the application.
- List most recent job first.

Dates of employment: (mm/dd/yr) From _____ To _____	Title of Positions	
Name of employing firm	Type of Business	Telephone Number
Street Address, City, State & Zip Code	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Supervisor	Salary: Starting \$ _____	Final \$ _____
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$ _____
Reason for leaving		

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Dates of employment: (mm/dd/yr) From _____ To _____	Title of Position	
Name of employing firm	Type of Business	Telephone Number
Street Address, City, State & Zip Code	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Supervisor	Salary: Starting \$ _____	Final \$ _____
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$ _____
Reason for leaving		

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Name of employing firm	Type of Business	Telephone Number
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Supervisor	Salary: Starting \$ _____	Final \$ _____
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$ _____
Reason for leaving		

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Dates of employment: (mm/dd/yr) From _____ To _____	Title of Position	
Name of employing firm	Type of Business	Telephone Number
Street Address, City, State & Zip Code	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Supervisor	Salary: Starting \$	Final \$
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$

Reason for leaving

Dates of employment: (mm/dd/yr) From _____ To _____	Title of Position	
Name of employing firm	Type of Business	Telephone Number
Street Address, City, State & Zip Code	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Supervisor	Salary: Starting \$	Final \$
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$

Reason for leaving

Dates of employment: (mm/dd/yr) From _____ To _____	Title of Position	
Name of employing firm	Type of Business	Telephone Number
Street Address, City, State & Zip Code	May we contact for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Supervisor	Salary: Starting \$	Final \$
Description of duties	Incentive Earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	Average annual incentive \$

Reason for leaving

If you have been unemployed for a period of three consecutive months or more within the past five years, please provide the dates of unemployment and an explanation below:

**APPLICANT’S CERTIFICATION, ACKNOWLEDGEMENT AND AUTHORIZATION:**

As an applicant for employment with Lowcountry Medical Group, LLD (“LCMG”), I hereby certify and represent to LCMG that all of the information contained in this Application for Employment and any accompanying documents or resume which I may submit in support of this application, is true, correct and complete and is not misleading. I submit this information to LCMG making specific representations about my skills, education, expertise and experience so that I may be evaluated in connection with seeking a position of employment. I recognize that LCMG will reasonably rely upon all of the information that I provide and represent to it and therefore, will be damaged by any misleading, incomplete, incorrect and/or false information that I submit and/or represent. I understand that, if any of the information contained in this Application for Employment (and accompanying documents or resume) is misleading, untrue, incorrect and/or incomplete, I will become ineligible for employment consideration or, if hired, my employment with LCMG will be terminated.

I understand and agree that LCMG may (in its sole discretion) choose to conduct a thorough investigation of me and my background. I hereby authorize and grant my irrevocable permission to LCMG to conduct a thorough background investigation, including, but not necessarily limited to, contacting and interviewing all of my former employers and all of my references regarding my entire background, whether positive or negative.

I further authorize all of my current and former employers and educational institutions, and all references, to provide information concerning me, my previous employment and/or my background. I hereby release all employers, educational institutions, or other individuals or entities which may provide information about me, from any and all liability whatsoever in connection with any statements made by them to LCMG, to ensure that their comments will be both candid and complete. I further release LCMG from any and all liability whatsoever in connection with conducting a thorough background investigation of me or from its use of any of the information that it obtains in the course of conducting such an investigation.

I understand and agree that neither this document, nor any offer of employment from LCMG constitutes an employment contract. And, if I am employed by LCMG, my employment will be based upon *mutual consent* and will be governed by the State of South Carolina’s *At-Will Doctrine*. Either I or LCMG, or both, in our sole discretion, may terminate the employment relationship at any time, for any reason or no reason, with or without notice or prior discipline, without incurring any liability to the other whatsoever. I understand that no representative of LCMG other than the Chief Operating Officer, is authorized to modify the at-will nature of my employment, and that the at-will nature of my employment may be modified only by a separate written employment contract containing a specified term of employment.

**I REALIZE THAT THIS APPLICATION FOR EMPLOYMENT IS NOT A CONTRACT.**

(Print) Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

Note: A photocopy and/or facsimile of this document shall be deemed an original.

# Lowcountry Medical Group, LLC

## Disclosure and Authorization for the Release of Information

Lowcountry Medical Group will use Research Services, LLC, a consumer reporting agency (CRA) as an agent to perform its employment related background check. The agency will provide a written report of its findings to Lowcountry Medical Group. I understand my prospective employer intends to utilize the investigation into my background for employment purposes only, and shall not disclose such information to any other party.

Above named CRA, Research Services, LLC. may utilize various sources of information including but not limited to: credit reporting agencies, workers compensation records including any and all injuries in compliance with the Federal Americans with Disabilities Act, Department of Motor Vehicle driving records, criminal records, current and former employers, military records, education records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information including but not limited to the above to Lowcountry Medical Group, and Research Services, LLC, a CRA.

I request, authorize and consent to the procurement of an Investigative Consumer Report and understand that they may contain information about my background, mode of living, character, work history, personal characteristics, professional standing and general reputation. This authorization in original or copy form shall be valid for one year from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by Lowcountry Medical Group if employment is denied because of information obtained from a CRA. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to Lowcountry Medical Group. I further understand that when requesting a copy of the report, proper identification will be required and I may direct my request to Research Services, LLC 124 Simsbury Road Building One, Avon, CT., 06001. California residents will automatically receive a copy of the report within 7 days of delivery to the employer. I understand that residents of all other states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined above.

\*\*\*\*\*PLEASE FILL OUT THIS FORM COMPLETELY\*\*\*\*\*

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES \_\_\_ NO \_\_\_  
(If "YES", in what State? \_\_\_\_\_ Year \_\_\_)

Print Name: \_\_\_\_\_

List ALL other first & last names ever used: \_\_\_\_\_  
(PRINT NAME)(YEAR LAST USED) (PRINT NAME)(YEAR LAST USED)

Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State Issued: \_\_\_\_\_ Expires: \_\_\_\_\_

CURRENT Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How long at address? \_\_\_\_\_

PREVIOUS Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How long at address? \_\_\_\_\_

Last School/College Attended \_\_\_\_\_ State \_\_\_\_\_ Last Year attended? \_\_\_\_\_

Did you Graduate? \_\_\_\_\_ If you graduated, indicate \_\_\_\_\_ Certificate \_\_\_\_\_ GED \_\_\_\_\_ Diploma

Registered and/or Graduated under what name? \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

**For EMPLOYER Use Only:** Requested by \_\_\_\_\_ PH: \_\_\_\_\_ FX: \_\_\_\_\_

Lowcountry Medical Group

Criminal (Indicate States) \_\_\_\_\_ Driver History \_\_\_\_\_ Employment \_\_\_\_\_ (#) Education \_\_\_\_\_ (#)

Social Security \_\_\_\_\_ Professional License \_\_\_\_\_ Sex Offender Registry \_\_\_\_\_ Incarceration \_\_\_\_\_ Credit \_\_\_\_\_

Student Conduct \_\_\_\_\_ Other \_\_\_\_\_

Phone: 860-678-0066

Fax: 860-678-0077 or 860-678-0099