

EMPLOYMENT APPLICATION

CONFIDENTIAL

TriValley Primary Care considers applicants for all positions without regard to race, color, religion, sex, veteran's status, national origin, age or disabilities or any other legally protected status, as outlined in federal and state employment laws.

Corporate Office 519 South 5th Street, Suite 130 Perkasie, PA 18944

Please Print the information below:

| Last Name: | First Name: | M. | I.: | Today's Dat | e: | |
|--|---|---------|-------------------------------|----------------|-----------------------|----------|
| Street Address: | , | City: | | | State: | Zip: |
| Home Phone: | Other Phone: | | | Social Secur | rity Number: | L |
| E-Mail Address: | | | egally eligible to w | | | |
| Have you ever filed an application with TriVa | alley Primary Care before? Yes | No Ha | we you ever worke | d under a diff | ferent name? Please s | specify: |
| If yes, when? | | | | | | |
| Have you ever worked for TriValley Primary Care or its former practices? Yes No How did you learn of this position? | | | | | | |
| If yes, when? | | | | | | |
| Do you have any relatives, other than a spous | Do you have any relatives, other than a spouse, already employed by TriValley Primary Care? | | | | | |
| If yes, please list name(s), relationship(s), position/office: | | | | | | |
| | | | | | | |
| EMPLOYMENT DESIRED | | | | | | |
| Position in which you are interested, check all that apply: | | | | | | |
| ADMINISTRATIVE POSITIONS | | | CLINICAL POSITIONS | | | |
| ☐ Administrative Support ☐ | Billing/Payment Processing | | ☐ Certified | Medical A | ssistant | |
| ☐ Referral Specialist ☐ | | | | | | |
| | Billing/Patient/Insurance Colle | ections | □ LPN | | | |
| ☐ Administrative Supervisor ☐ | Billing/Patient/Insurance Colle Billing | ections | □ LPN □ RN | | | |
| | | ections | | Supervisor | | |
| | Billing | ections | □ RN | • | | |
| ☐ Medical Records | Billing Other (specify): | ections | □ RN □ Clinical S □ Other (sp | ecify): | | |
| | Billing Other (specify): | ections | RN Clinical S | ecify): | | /hour |
| ☐ Medical Records | Billing Other (specify): | ections | ☐ RN ☐ Clinical S ☐ Other (sp | ecify): ry \$ | | /hour |

PERSONAL INFORMATION

| EDUCATION | | | | | | | |
|---|---|------------------------------|-----------------------|--|--|--|--|
| | Name & Location of School | Main Courses Taken | | Highest grade completed, Diploma, Certificate, or Degree | | | |
| High School | | | | | | | |
| College | | | NPANULE III | | | | |
| Vocational or | | | | | | | |
| Business School Nursing Education | | | | | | | |
| Lab, X-Ray, or other Training | | | | | | | |
| | e or finish your degree, why did you | leave school? | | | | | |
| | | | | | | | |
| Are you planning to put If yes, please explain: | ursue additional education? Yes | No No | | | | | |
| ii yes, piease expiaiii. | | | | | | | |
| | ctivities, offices held, or other quality exclude those activities which mattus, or disability. | | | | | | |
| Please list membership | os in Professional Organizations: | | | | | | |
| | 3 | | | | | | |
| | | | | | | | |
| Type | PROFESSIONAL Organization or State Issuing | LICENSES/CERTIFIC | ATIONS | License Number | | | |
| | organization of State Issuing | Expiration Date | | License (valide) | | | |
| | | | | | | | |
| | nced a lapse in licensure or has you | r license ever been revoked? | ☐ Yes | □ No | | | |
| If yes, please explain: | | | | | | | |
| | | | | | | | |
| ADDITIONAL SKILLS | | | | | | | |
| ☐ Microsoft Word | d Calculator | Phlebotomy | ☐ Elect | ronic Health Records | | | |
| ☐ Microsoft Exce | l 🚨 Bookkeeping | ☐ EKG Setup | ☐ Perso | onal Computer | | | |
| ☐ Navinet | ☐ Account Collection | ons 🛚 Injections | ☐ Medical Terminology | | | | |
| Other (please sp | pecify): | | | | | | |
| Please use the space | e below to describe your inter | rest in the medical field an | | d aptitudes that qualify | | | |
| | | | | | | | |
| | with TriValley Primary Care. | | on in your nor | | | | |
| | | | on in your nor | | | | |

| | EM | IPLOYME | NT RECORD | | | | |
|---|----------------------|-------------------|---------------|-------------------|-----------------|------------|--|
| It is essential that this portion of the a | | | | ume, but this s | section must be | completed | |
| in your handwriting as well. Please list Employer's Name: | st present or n | Supervisor's Na | ployer first. | | Employed From | | |
| | | | | | | | |
| Address: | | Contact Phone | Number: | | To: | | |
| Briefly describe you duties: | | | | | | | |
| | | 10 1 10 | | | Ct. + D | E'1 D | |
| May we contact this employer? | □ No If no, why not? | | | Start Pay: | Final Pay: | | |
| Reason for leaving: | | | | | | | |
| | | | | | | | |
| Employer's Name: | | Supervisor's Na | ame: | | Employed From: | | |
| Address: | | Contact Phone | Number: | | То: | | |
| Briefly describe you duties: | | | | | | | |
| | | | | | | | |
| May we contact this employer? | □ No | If no, why not? | | | Start Pay: | Final Pay: | |
| | | | | | | | |
| Reason for leaving: | | | | | | | |
| Employer's Name: | | Supervisor's Na | ame: | | Employed From: | | |
| Address: | | Contact Phone | Number: | | To: | | |
| Briefly describe you duties: | | | | | | | |
| | | | | | | | |
| May we contact this employer? Yes | □ No | If no, why not? | | | Start Pay: | Final Pay: | |
| That we contact this on project | | | | | | | |
| Reason for leaving: | | | | | | | |
| Please list additional employers here: | | | | | | | |
| Employer's Name: | Employed Fr | rom: Employed To: | | Title | Title: | | |
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| Please explain all periods of unemployment: | | | | | | | |
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| | DE | DCONAL I | DEEEDENCES | | | | |
| PERSONAL REFERENCES Please list two personal references, other than relatives and former employer, who have known you for the past five years or more. | | | | | | | |
| Name | | | | itle/Relationship | | | |
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| Have you ever been convicted of a felony or entered into pretrial | | | Yes | | No | |
|--|---|---------------|------------|-------------|--------------|--|
| diversion program in connection with a felony charge? | | | | | | |
| If Yes, for what, where, and when? | | | | | | |
| Have you ever been terminated for | | Yes | | No | | |
| Absenteeism, tardiness, failure to notify your continuous. | omnany when absent or | _ | | _ | | |
| other attendance related reasons? | ompany when absent, or | | | | | |
| • Theft, unauthorized removal of company prope | erty, or related offense? | | | | | |
| The state of the s | | _ | | _ | | |
| • Fighting, assault, or related offense? | | | | | | |
| Being under the influence of alcohol or drugs of | or for the possession, use or | | | | | |
| abuse of alcohol or drugs? | | | | | | |
| • Insubordination? | | | | | | |
| This section is for the hiring supervisor's use. Completion is optional. | I understand that: | | | | | |
| Screening Call/Interview: | If employed, I agree to conform to the r TriValley Primary Care and acknowled | | | | | |
| Salary ExpectationSchedule | regulations may be changed or withdra Care at any time. | | | | | |
| Availability Date | I authorize TriValley Primary Care to it | | | | | |
| On Site Interview: | contained within this application, included education, licensure, credit history and | | | | | |
| Participants: | cooperate in such investigations. • I release from all liability and responsit | nility all ne | rsons | | | |
| Other Notes: | I release from all liability and responsibility all persons, companies or corporations supplying such information to | | | | | |
| | TriValley Primary Care regarding my e licensure, credit history and activities. | | | | | |
| | I release from all liability and responsible Care which might result from making s | | | | | |
| | stated above. | | | | | |
| | I certify that the information in this appropriate. I understand that false states | | | f | | |
| | fact are sufficient grounds for rejection dismissal after employment. | for employ | ment or | | | |
| | My application with TriValley Primary | | | | | |
| understanding that nothing contained w granting of an interview is intended to | | | | | F | |
| | and TriValley Primary Care for either employment or for the provision of any benefit. I acknowledge that any offer of employment may be | | | | | |
| | withdrawn for any reason and without prior notice to me at TriValley's option. I understand that employment with TriValley Primary Care is considered at will, which means that employment may be terminated at | | | | | |
| | | | | | | |
| | any time by either myself or TriValley | for any reas | son not ex | pressly | | |
| | prohibited by law. Any written or oral supervisor, corporate officer, or other a | gent of Tri | Valley sho | | | |
| | relied upon by any prospective or exist I understand that my employment will | | | al basis of | | |
| at least 90 days, during which time I will not be eligible for most benefits. This provisional period will be used to assess my abilities | | | | | | |
| | to perform the essential functions of my | y position. | | | | |
| My signature below indicates that I understand the contents of this application and have not withheld any information requested and | | | | | | |
| that the statement I have made are true and correct. This application remains active for 30 days. | | | | | | |
| | | | | | | |
| Signature of applicant | | Date | | | | |
| REFERENCE AUTHORIZATION | | | | | | |
| I hereby authorize the addressed individual, company, or inst | | y Care w | ith any | informati | ion they may | |
| have concerning me which they have on record or otherwise, | and do hereby release the addresse | ed individ | dual, co | mpany or | institution | |
| and all individuals connected therewith, including TriValley Primary Care, from any liability for any damage whatsoever incurred in | | | | | | |
| furnishing such information. | | | | | | |
| | | | | | | |
| Signature of applicant | | Date | | | | |