MED ONE PHARMACY
EMPLOYMENT APPLICATION

PERSONAL INFORMATION

DATE APPLYING / /

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER
HOME ADDRESS		**CITY**	**STATE** / **ZIP**
HOME PHONE		**CELL PHONE**	**REFERRED BY**

EMPLOYMENT DESIRED

POSITION	DATE AVAILABLE	SALARY DESIRED	INTERESTED IN (CHECK ALL THAT APPLY)
			☐ FULL-TIME ☐ PART-TIME ☐ TEMPORARY ☐ SUMMER

TIMES AVAILABLE			HAVE YOU APPLIED TO THIS COMPANY BEFORE?	IF SO, WHEN?
MONDAY	TUESDAY	WEDNESDAY		
FROM TO	FROM TO	FROM TO	☐ YES ☐ NO	
THURSDAY	FRIDAY	SATURDAY	ARE YOU CURRENTLY EMPLOYED?	IF SO, MAY WE CONTACT YOUR PRESENT EMPLOYER?
FROM TO	FROM TO	FROM TO	☐ YES ☐ NO	☐ YES ☐ NO

EDUCATION & MILITARY SERVICE

	NAME AND LOCATION OF SCHOOL		DEGREE OR AREA OF STUDY	YEARS ATTENDED	GRADUATED (CHECK ONE)
HIGH SCHOOL	NAME / ADDRESS				☐ YES ☐ NO
	CITY / STATE / ZIP				
COLLEGE	NAME / ADDRESS				☐ YES ☐ NO
	CITY / STATE / ZIP				
OTHER	NAME / ADDRESS				☐ YES ☐ NO
	CITY / STATE / ZIP				
U.S. MILITARY SERVICE	BRANCH OF SERVICE	TECHNICAL SPECIALIZATION	RANK ATTAINED		

FORMER EMPLOYERS

LIST BELOW YOUR LAST FOUR EMPLOYERS, STARTING WITH MOST RECENT ONE FIRST.

DATE (MONTH AND YEAR)	NAME AND ADDRESS OF EMPLOYER	POSITION	SALARY	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				

FROM TO				
FROM TO				

REFERENCES

GIVE THE NAMES OF THREE PERSONS NOT IN YOUR FAMILY WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	PHONE NUMBER AND/OR EMAIL	RELATIONSHIP	YEARS KNOWN

AUTHORIZATION

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND AUTHORIZE THE REFERENCES AND EMPLOYERS LISTED ABOVE TO GIVE YOU ANY PERTINENT INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE, CONCERNING MY PREVIOUS EMPLOYMENT. I RELEASE THE COMPANY FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM UTILIZATION OF SUCH INFORMATION. THIS WAIVER DOES NOT PERMIT THE RELEASE OR USE OF DISABILITY-RELATED OR MEDICAL INFORMATION IN A MANNER PROHIBITED BY THE AMERICANS WITH DISABILITIES ACT (ADA) AND OTHER RELEVANT FEDERAL AND STATE LAWS. I ALSO UNDERSTAND AND AGREE THAT NO REPRESENTATIVE OF THE COMPANY HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING, UNLESS IT IS IN WRITING AND SIGNED BY AN AUTHORIZED COMPANY REPRESENTATIVE. IN COMPLIANCE WITH FEDERAL LAW, ALL PERSONS HIRED WILL BE REQUIRED TO VERIFY IDENTITY AND ELIGIBILITY TO WORK IN THE UNITED STATES AND TO COMPLETE THE REQUIRED EMPLOYMENT ELIGIBILITY VERIFICATION UPON HIRE.

IF HIRED, EMPLOYEE WILL BEGIN A PROBATIONARY PERIOD THAT WILL LAST 90 CALENDAR DAYS. THE 90 DAY PROBATIONARY PERIOD WILL BE COMPLETED FOR ALL NEW EMPLOYEES. BY COMPLETING THIS PROBATIONARY PERIOD, AN EMPLOYEE IS NOT GUARANTEED CONTINUED EMPLOYMENT FOR ANY TERM.

SIGNATURE	DATE

---------- DO NOT WRITE BELOW THIS LINE ----------

INTERVIEWED BY		INTERVIEW DATE	
REMARKS			
POSITION	HIRE DATE	START DATE	SALARY/WAGES