

# Movement Systems Physical Therapy

## Application for Employment

Instructions: Please furnish information requested on this form. Please supply a complete resume/ curriculum vita on a separate sheet. Please type or print clearly all information. We appreciate your interest in working here and are sincerely interested in your qualifications.

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Have you within the last (7) years been convicted of an offense involving drugs, theft or inflicting bodily injury? Yes  No   
(A conviction will not necessarily bar you from employment)

If yes, explain fully: \_\_\_\_\_

How did you become aware of employment opportunities? \_\_\_\_\_

### JOB INFORMATION

Positions applying for: 1 \_\_\_\_\_ 2 \_\_\_\_\_

Are you able to perform the essential functions of the position(s) for which you have applied as set forth in the job description, with or without reasonable accommodations?  
Yes  No

If no, please explain: \_\_\_\_\_

Status of work you will accept: Full Time  Part Time  On Call  Temporary (6 months or less)

Check days you are available for work: Mon  Tues  Weds  Thurs  Fri

Can you work any shift? Yes  No  –If not, what shift can you work?

7:00 a.m. to 3:30 p.m.  8:00 a.m. to 4:30 p.m.  10:00 a.m. to 7:00 p.m.

Other (Please specify hours available): \_\_\_\_\_

### EMPLOYMENT HISTORY

Please provide information about all employers in the past twelve (12) years with the most recent Employer first. Attach sheet if necessary. (Must complete in full, even if attaching resume.)

Job Title: \_\_\_\_\_ Dates of Employment (Mo./Yr.—Mo./Yr.): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

May we contact? Yes  No  Last Salary: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

Major Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_ Last Name Used: \_\_\_\_\_

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Job Title: \_\_\_\_\_ Dates of Employment (Mo./Yr.—Mo./Yr.): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

May we contact? Yes  No  Last Salary: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

Major Duties: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_ Last Name Used: \_\_\_\_\_

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Job Title: \_\_\_\_\_ Dates of Employment (Mo./Yr.—Mo./Yr.): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

May we contact? Yes  No  Last Salary: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

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Major Duties: \_\_\_\_\_

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Reason for Leaving: \_\_\_\_\_ Last Name Used: \_\_\_\_\_

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Job Title: \_\_\_\_\_ Dates of Employment (Mo./Yr.—Mo./Yr.): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

May we contact? Yes  No  Last Salary: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

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Major Duties: \_\_\_\_\_

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Reason for Leaving: \_\_\_\_\_ Last Name Used: \_\_\_\_\_

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**PROFESSIONAL REGISTRATION / LICENSE**

State \_\_\_\_\_ Number \_\_\_\_\_ Date of Exp. \_\_\_\_\_

If you do not have required registration or license, have you applied for one? Yes  No

If an examination is required, what date are you scheduled to take the examination? \_\_\_\_\_

If not licensed in Washington State, have you applied for reciprocity or endorsement?

Yes  No

**EDUCATION INFORMATION**

Type of School	Name and Address Including City, State and ZIP code	How Many Years Attended?	Graduated? Yes / No	Courses of Majors
High				

School					
College		Dates Attended (Mo / Yr)			
		Start	End		
Post Graduate					
Other					

**SKILLS INVENTORY**

Indicate “**T**” if you have training in this skill.  
 Indicate “**E**” if you have experience in this skill.  
 Indicate “**B**” if you have both training and experience.

Business / Clerical

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Accounts Payable                | <input type="checkbox"/> ICD-9 Coding        | <input type="checkbox"/> Receptionist |
| <input type="checkbox"/> A/R Billing                     | <input type="checkbox"/> Medical Terminology | <input type="checkbox"/> Dictaphone   |
| <input type="checkbox"/> Bookkeeping                     | <input type="checkbox"/> Medical Insurance   | <input type="checkbox"/> Filing       |
| <input type="checkbox"/> Personal Computers              |  |                                       |
| <input type="checkbox"/> Word Processing Programs: _____ |  |                                       |
| <input type="checkbox"/> Other Software (List): _____    |  |                                       |

Supervisory Background

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Management / Supervision | <input type="checkbox"/> Budget Preparation | <input type="checkbox"/> Scheduling |
|---|---|-------------------------------------|

Please list any other qualifications that you feel would especially suit you for working in our organization: \_\_\_\_\_  
 \_\_\_\_\_

Are you fluent in any foreign languages/signing? List: \_\_\_\_\_

**PROFESSIONAL REFERENCES**

Name	Title	Phone
1.		
2.		
3.		

**APPLICANT DISCLOSURE AND CONSENT**

I certify that the information set forth in this Application for Employment is true and complete to the best of my knowledge. I understand that, if employed, falsified statements on this application or its attachments shall be considered sufficient cause for my dismissal.

I understand that my employment shall be contingent upon proof of identity and verification of eligibility for employment in the United States in accordance with the immigration Reform and Control Act of 1986. I further understand that my employment is contingent upon the checking of references, requests for criminal history information and an employment physical if required.

I consent to and authorize Movement Systems Physical Therapy, P.S. and its personnel to request any information concerning my previous employment record as indicated on this Application for Employment. I hereby release all parties and persons connected with any request for information from all claims, liabilities and damages for whatever reason arising out of furnishing such job related information.

In consideration of my employment, I agree to conform to the rules and regulations of Movement Systems Physical Therapy, P.S. My employment or compensation can be terminated with or without cause, and with or without notice at any time, at the option of Movement Systems Physical Therapy, P.S. I understand that no supervisor or representative of Movement Systems Therapy, P.S. other than the President 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.

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

\_\_\_\_\_  
*Signature of Applicant* *Date*

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**APPLICANT – Do not write below this line**

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**TO BE COMPLETED AFTER EMPLOYED**  
**(To be completed by Hiring Supervisor/Department Manager)**

Starting Date: \_\_\_\_\_ Job Title: \_\_\_\_\_

Full Time  Part Time  On Call  Temporary  Work Study

Pay Rate: \_\_\_\_\_ Hours/Pay Period: \_\_\_\_\_ Shift: \_\_\_\_\_

New Position  Replacement  Name of Person Replaced: \_\_\_\_\_

References Checked: Yes  (Attached)

Date Scheduled for Orientation: \_\_\_\_\_

Professional License/Certification: \_\_\_\_\_

Verified? Yes  No  Attached  Not Applicable  Rehire? Yes  No

President Signature \_\_\_\_\_