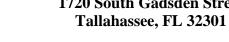
BOND COMMUNITY HEALTH CENTER, INC. 1720 South Gadsden Street





PROVIDER APPLICATION FOR EMPLOYMENT

(Please print or type)

Date:

POSITION APPLIED FOR		MINIMUM SALARY ACCEPTABLE			
LAST NAME FIRST M	IDDLE MAIDEN	SOCIAL SECURITY			
ADDRESS		TEX EDVONE NUMBER			
ADDRESS	FLOOR/SUITE/ROOM	TELEPHONE NUMBER			
CITY STATE	ZIP	DATE OF BIRTH			
GITI	ZII	DATE OF BIRTH			
ARE YOU A U.S. CITIZEN?	IF NOT A U.S. CITIZEN, HAVE	YOU THE RIGHT TO REMAIN			
□ YES □ NO	PERMANENTLY IN THE U.S.?				
	□ STUDENT □ PERMANE	NT □ J-1 VISA □ VISA			
DO YOU SPEAK ANY LANGUAGES(BOND COMMUNI TY HEALTH CENTER,			
		BOND COMMUNITY HEALTH CENTER,			
ADDITION TO ENGLISH?	INC?				
\square YES \square NO					
If yes, please list:					
HAS YOUR LICENSED EVER BEEN:	HAVE YOU EVER HAD A PRO	FESSIONAL MALPRACTICE LIABILITY			
☐ Limited ☐ Suspended ☐ Revoked in any jurisdiction? ☐ No.	ACTION COMMENCED AGAI	ACTION COMMENCED AGAINST YOU? ☐ YES ☐ NO			
Revoked in any jurisdiction:		If yes, provide summary and outcome on separate sheet:			
	List your malpractice carrier	-			
WHEN CAN YOU START?					
EDUCATION					

	NAME & ADDRESS OF SCHOOL	CONCENTERATION	DID YOU COMPLETE?	DATES	DEGREE OR DIPLOMA
COLLEGE					
MEDICAL/DENTAL SCHOOL					
INTERNSHIP					
RESIDENCY					
OTHER					

SPECIALTY BOARD CERTIFICATIONS □ Eligible □Certified		STATE OI	STATE OF FLORIDA LICENSE NO.				DEA REGISTRATION NO/UPIN NO. / Expiration Date:		
Date:		Expiration NPI NO.	Expiration Date:NPI NO.				Medicaid Provider No Medicare Provider No		
HOSPITAL AFFILIATIONS		CAPACIT 	CAPACITY				DATES		
	ENT RECORD (list most								
DATES	NAME & ADDRESS OF EMPLOYER		POSITION	LAST SALARY	REASON FOR LEAVING		SUPERVISOR & CONTACT TELEPHONE NUMBER		
FROM									
TO									
FROM									
ТО									
FROM									
TO									
FROM									
ТО									
FROM									
ТО									
REFERENC	ES								
NAME & ADDRESS		YEARS KNOWN	OCCU	OCCUPATION		PHONE NUMBER			
Consent to th	e release of information	by any former e	employer to Ror	nd Community	Health Ce	nter. Inc	·_		
certify that a	all of the statements made e sufficient reason for my inations as may be require	by me on this ap	oplication are true offered a posi	ne and may be intion I consent to	nvestigated a pre-emp	l. If any oloyment	are said to be false, this physical and any future		

SIGNATURE: DATE:

Bond Community Health Center, Inc. reserves the right to conduct random drug testing.