Darrell Parsons, M.D., P.A.
318 North Alleghaney, Suite 100
Odessa, TX 79761
432-640-2929

Application For Employment Date: _____

We are an equal opportunity employer. Race, color, religion, sex, disability and national origin or any other basis protected by statute are not factors in employment, promotion, and compensation. Employment in this office may be contingent upon successfully passing a drug screening test. Thank you for applying with our office.

PERSONAL INFORMATION

Legal Name as it appears on SS card:(Last) (First) (Middle)	**□ Home or □ Cell Phone Number**
Home Address (Street/PO BOX) (City) (State) (Zip)	**□ Business or □ Pager Number**
E-mail Address:	**D.O.B.** _____/_____/_____
Are you authorized to work in the U.S. on an unrestricted basis? □ Yes □ No	**S.S. #** _____-_____-_____

Are you over the age of 18? □ Yes □ No

Have you ever been convicted of a felony? □ Yes □ No
If yes, please explain:_____

Can you fluently speak/read a language other than English? □ Yes □ No
Language:

EMPLOYMENT DESIRED

What position(s) do you desire?

Are you willing to cross train? □ Yes □ No
If so, what positions?

Do you have obligations with employers, school, or caring for a family member that would interfere with this position? □ Yes □ No
If yes, explain:

Mark only those you will accept: **□ Full Time □ Part Time**	**Date available for employment:**

Do you have any relatives employed by this organization? □ Yes □ No
If yes, Name: _____ Relationship: _____ Dept.:_____

EDUCATION

NAME	DATES (from – to)	GRADUATE	DIPLOMA/DEGREE
High School:		**□ Yes □ No □ GED**	
Tech/College/University		**□ Yes □ No**	
Tech/College/University		**□ Yes □ No**	

In addition to your work history(reverse side), what other experiences, skills, or qualifications would especially fit you for work with our company? _____

_____

_____

Are you currently: □Registered □Licensed □Certified
Eligible for: □Registration □Licensure □Certification

Type	State Issued	Exp. Date	No.	Verified By:

Clerical Skills: □ Type _____wpm □Transcribe dictation □File □Other _____

□Computer proficient on: □Word □Excel □Access □Other _____

Employment History

Start with the most recent employment, give a complete record of all employment and reasons for periods of unemployment including military service and volunteer service for the past ten years.

NOTE: If additional space is needed for your employment record, please ask for an "Employment Record Supplement."

Company Name:	**Specific Duties:**	
Street Address **Telephone**		
City & State		
Job Title	**If currently employed, may we contact at this time?** □ **Yes** □ **No**	
Name and title of immediate supervisor:	**Starting Salary** $	**Final Salary** $
From: Month/Year **To: Month/Year** **Name Used if different:** **Dates Employed**	**Reason for leaving**	
Company Name:	**Specific Duties:**	
Street Address **Telephone**		
City & State		
Job Title	**If currently employed, may we contact at this time?** □ **Yes** □ **No**	
Name and title of immediate supervisor:	**Starting Salary** $	**Final Salary** $
From: Month/Year **To: Month/Year** **Name Used if different:** **Dates Employed**	**Reason for leaving**	
Company Name:	**Specific Duties:**	
Street Address **Telephone**		
City & State		
Job Title	**If currently employed, may we contact at this time?** □ **Yes** □ **No**	
Name and title of immediate supervisor:	**Starting Salary** $	**Final Salary** $
From: Month/Year **To: Month/Year** **Name Used if different:** **Dates Employed**	**Reason for leaving**	

I authorize investigation of all information contained in this Application for Employment. I affirm that all the information contained in this document is true and complete and that any misrepresentation, falsification or willful omission herein shall be sufficient reason for dismissal or refusal of employment. I understand that any employment with this organization is contingent on my passing the pre-employment health examination/tests. If this application is accepted I understand that the terms of my employment, including my working conditions, compensation, benefits, hours of work, work schedule and job assignment will be determined solely by this organization. In addition, I grant this organization permission to contact any previous employer listed on this application for purposes of reference checks, unless otherwise noted on this document. I also grant permission to any such previous employer to disclose any and all information concerning my previous employment.

X ____ ____________________

APPLICANT'S SIGNATURE **DATE**

Please complete below questions and sign and date:

Are you currently taking controlled substances by prescription or otherwise?
□ Yes □ No

For purposes of the above questions:
The term "currently" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two (2) years;
The term "controlled substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed prescriber's direction, as well as those substances used illegally;
The phrase "ability to provide health care services" includes the following:
(a) The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments;
(b) The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and
(c) The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes," to any of the questions above, please answer(i) and (ii), below.
(i) Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? □ Yes □ No

(ii) Are you currently participating in a professionally supervised program that monitors you in order to assure that you are not illegally utilizing the controlled substances? □ Yes □ No

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? □ Yes □ No

For purposes of this question, the term "medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities as defined in the American with Disabilities Act ("ADA"), HIV/AIDS, tuberculosis, drug addiction and alcoholism.
If you answered "yes", please answer questions a and b below.

(a) Are any limitations that may be related to your medical condition ameliorated by current ongoing treatment or participation in a monitoring program? □ Yes □ No

(b) Are any limitations that may be related to your medical condition overcome by the manner in which you have chosen to provide health care services? □ Yes □ No

3. Have you ever been convicted of a crime (not including traffic violations)?
□ Yes □ No

4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? □ Yes □ No

If you answered "Yes" to any of the above, please attach explanation and related documents.

X _____ _____
APPLICANT'S SIGNATURE **DATE**