

NEW VISION MEDICAL LABORATORY
750 WEST HIGH STREET SUITE #400, LIMA, OHIO 45801
APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

Date: _____

Position: _____ Date Available: _____ Salary Desired: _____

Name: _____ Social Security # _____ - _____ - _____

Present Address: _____ Home Phone# _____ - _____ - _____

Day Time Phone Number _____ - _____ - _____

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

Name _____ Relationship _____

Address _____ Phone Number _____

If you are related to anyone employed here please give name _____

Employment Availability _____ 1st _____ 2nd _____ 3rd / _____ Full Time _____ Part Time

If the position requires, are you willing to rotate your work hours? _____ Yes _____ No

Have you ever completed an application here in the past? _____ Yes _____ No

New Vision Medical Laboratory is committed to providing a smoke/tobacco free environment and does not employ current tobacco users. I verify that I am not a user of any type of tobacco product. _____ Yes _____ No

Are you, or have you ever been excluded from providing services under Medicaid/Medicare or any other federally funded program? _____ Yes _____ No

Have you ever been convicted of anything other than a minor traffic violation? _____ Yes _____ No

If yes please describe: _____

LIST YOUR MOST PRESENT JOB FIRST FOLLOWED BY YOUR PREVIOUS EMPLOYMENT HISTORY.

FIRMS	RATE	POSITION OR NATURE OF WORK
NAME		
ADDRESS		
FROM To		
REASON FOR LEAVING		

FIRMS	RATE	POSITION OR NATURE OF WORK
NAME		
ADDRESS		
FROM To		
REASON FOR LEAVING		

FIRMS	RATE	POSITION OR NATURE OF WORK
NAME		
ADDRESS		
FROM To		
REASON FOR LEAVING		

EDUCATIONAL DATA

TYPE OF SCHOOL	CITY	GRADUATE?	DEGREE OR MAJOR STUDIES
HIGH SCHOOL			
COLLEGE OR UNIVERSITY			
BUSINESS SCHOOL			
SPECIAL TRAINING			

REGISTRATION NUMBER

If the position requires a registration number, please state: ____ Yes ____ No

State _____ Registration # _____ National Registration # _____

Is your Registration Number current? ____ Yes ____ No

PERSONAL REFERENCE

NAME	ADDRESS	BUSINESS	PHONE	YEARS KNOWN

USE THIS SPACE FOR ANY ADDITIONAL REMARKS THAT WOULD BE HELPFUL IN EXPLAINING YOUR QUALIFICATIONS:

I certify that the foregoing responses to each question are true and complete to the best of my knowledge and that I have not knowingly withheld any requested information which would affect my consideration for employment. I understand that false or incomplete information may be cause for immediate dismissal. I agree to permit St. Rita's Medical Center and/or New Vision Medical Laboratory to contact my past employment, schools, and references and further agree not to hold anyone liable for information received. I understand that my employment is based upon a physical examination to determine my ability to perform the essential functions of the position for which I will be considered. This application is void after six (6) months if not renewed.

Date: _____ Signature: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Comments, Human Resource Department: _____

Signature: _____

DISPOSITION BY DEPARTMENT OR SUPERVISOR

- ☐ Accepted. (Attach completed status report form)
- ☐ Withholding final decision. Send another
- ☐ Rejected. Send another
- ☐ No openings at this time.

COMMENTS: DEPARTMENT HEAD: _____



There is nothing available at this time.

Please feel free to fill out an application and
send us your resume.

Please mail your information to:

New Vision Medical Laboratories
Resume/Application
750 W. High Street, Suite #400
Lima, Oh 45801.

**Thank you for considering New Vision
Medical Laboratories as your place
of employment.**