

At-Will Employment Application



Emergency Contact: _____
 Name Street City State/Zip

() - _____
 Phone Number Relationship

REFERENCES:

List below three individuals not related to you, whom you have known for at least one year.

NAME	ADDRESS & TELEPHONE	RELATIONSHIP	YEARS ACQUAINTED

EMPLOYMENT INFORMATION-

**Please complete all information below DO NOT STATE
 "Please see attached resume".**

MAY WE CONTACT YOUR PRESENT EMPLOYER? Yes No

Please list below your last four employers, beginning with the most recent:

Date Month and Year	Name, Address and Phone Number of Employer	Starting/Ending Salary	Job Title or Type of Work	Supervisor Name/Title	Reason for Leaving
From To					
From To					
From To					
From To					

Please read the following statement carefully before signing to indicate your understanding:

APPLICANT'S CERTIFICATION AGREEMENT

I understand that if I receive a conditional job offer, and prior to beginning employment, I may be requested to undergo a pre-employment medical examination. In the event that I have a disability that will affect my ability to take the test, I will so inform the Company prior to the administration of the test so that a reasonable accommodation can be made. The Company reserves the right to require medical documentation regarding the need for accommodation.

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that any falsification, misrepresentation or omission of facts on this application (or any required documents) will be cause for denial of employment or immediate termination of employment, regardless of when or how discovered. If submitting a resume, I affirm that all information included is true. I authorize the investigation of all statements contained in this application for any employment-related purpose and release from all liability any persons or employers supplying such information, and I also release HUDSON PHYSICIANS from all liability which might result from making the investigation.

I agree that if I am offered and accept a position, I will conform to all existing and future HUDSON PHYSICIANS rules and regulations and I understand that HUDSON PHYSICIANS reserves the right to change wages, hours and working conditions as deemed necessary. The use or acceptance of this form does not indicate any positions are available, and in no way obligates me or HUDSON PHYSICIANS. I understand that any employment offer is contingent upon my providing valid proof of identity and eligibility to work in order to comply with the Immigration Reform and Control Act of 1986.

I HEREBY UNDERSTAND AND ACKNOWLEDGE THAT, IF HIRED, MY EMPLOYMENT RELATIONSHIP WITH HUDSON PHYSICIANS WILL BE AT-WILL AND VOLUNTARY. THIS MEANS THAT THE EMPLOYEE MAY RESIGN AT ANY TIME, AND THE EMPLOYER MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE. THE AT-WILL EMPLOYMENT RELATIONSHIP MAY NOT BE CHANGED ORALLY, BY CONDUCT, OR BY ANY WRITTEN DOCUMENT UNLESS SUCH CHANGE IS SPECIFICALLY INCLUDED IN A WRITTEN EMPLOYMENT CONTRACT.

I agree to submit to drug screening tests, if requested of me at any time prior to employment or during any employment period. Also, during any employment period I may be required to be alcohol and/or drug screened for cause, or if I am injured while working for HUDSON PHYSICIANS or if I am selected for a random drug and/or alcohol screening. I hereby release HUDSON PHYSICIANS, firms, and persons from any liability or damage whatsoever resulting from alcohol and/or drug screening or the providing of such information or related information to HUDSON PHYSICIANS.

I have read and reviewed the information provided in this application and the above statements. By signing this application for employment, I certify that I understand all parts of it and have answered all questions completely and fully.

Applicant's Signature

Date Signed