

All Dental Solutions

Please fill out ALL information following regardless of information on resume. This cannot be considered complete without it.

Application for Employment

Please print legibly in black ink

Today's Date ____ / ____ / ____

PERSONAL INFORMATION

Name	Last	First	Middle	Home Telephone No. () ()	Cell No. () ()
Address	Number	Street	City	State	Zip
Work Schedule Desired			When can you start employment? Date: ____ / ____ / ____	Any issues to know regarding schedule for this position? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Will you be able to meet the scheduling requirements of the job as noted? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Full Time (M-Th) <input type="checkbox"/> Part Time: <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> We <input type="checkbox"/> Th <input type="checkbox"/> Temporary _____			Are you 18 years or older? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you currently authorized to work in the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>	Can you perform the essential functions of the job with or without reasonable accommodation? Yes <input type="checkbox"/> No <input type="checkbox"/>
Will you work overtime if necessary? Yes <input type="checkbox"/> No <input type="checkbox"/>					
By law, proof of work authorization will be required of all applicants within 72 hours of commencement of employment.					

EMPLOYMENT STATUS

Are you currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever filed an application with Dentist office before? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes: Date: ____ / ____ / ____ Position: _____
	Have you ever been employed by Dentist office before? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes: Dates of Employment: ____ / ____ / ____ to ____ / ____ / ____ Position: _____

EDUCATION

	High School	Trade/Technical School or College/University	Graduate School or Professional Courses	Additional Programs or Degrees
Name of School				
City and State				
Graduation/completion date or # years Completed				
Course of Study or Major				
Honors Received				
Additional information				

SKILLS

Although we will train and don't expect anyone to have experience with all the technology and treatment that All Dental Solutions has to offer, we want to understand what your experience level is in the following areas:

Enter your level of experience and add specific details where possible (brand, years of experience, etc.):

Proficient
 Know it well
 Know, and could use more training
 Have used it
 Know what it is
 None

Eaglesoft	_____
Dental Intel	_____
Lighthouse	_____
Digital 3D scanner	_____
Intra-oral camera	_____
Digital x-ray/handheld radiography	_____
Digital impressions/CAD-CAM	_____
3D printing	_____
Same day crown milling	_____
CBCT	_____
Dental laser (hard tissue)	_____
Dental laser (soft tissue)	_____
Dental Photography	_____
Clear Aligners	_____
LightForce 3D brackets	_____
Dental Implants-Surgical	_____
Dental Implants-Restoration	_____
OSHA/HIPAA certification (date)	_____
CPR certification (date)	_____
Lab work fabrication	_____

Please indicate any additional skills you DO have which may be relevant to the position sought, not mentioned above:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any professional licenses?

Yes No

If yes, please describe/last date of licensure:

Please describe any specialized study, job training, apprenticeship, or extracurricular activities which may be relevant to the position sought:

Any additional information that you would like to share with us:

EMPLOYMENT RECORD

Please list all employment, including military service and any self-employed periods. **Give all information requested below even if duplicated on your resume.** Start with your present position and proceed chronologically backward. If required, use a separate piece of paper. You may include any verifiable work performed on a volunteer basis.

Most Recent Employer	Address	Phone Number of main office () Phone Number of Supervisor ()
Position(s) Held	Work Performed (Title of position)	Supervisor's Name
Dates Employed From ___ / ___ / ___ To ___ / ___ / ___	Do we have permission to call <u>main office</u> for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> Do we have permission to call <u>supervisor</u> for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> If no to either, please explain _____	
Reasons for Leaving		
Previous Employer	Address	Phone Number of main office () Phone Number of Supervisor ()
Position(s) Held	Work Performed (Title of position)	Supervisor's Name
Dates Employed From ___ / ___ / ___ To ___ / ___ / ___	Do we have permission to call <u>main office</u> for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> Do we have permission to call supervisor for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> If no to either, please explain _____	
Reasons for Leaving		
Previous Employer	Address	Phone Number of main office () Phone Number of Supervisor ()
Position(s) Held	Work Performed (Title of position)	Supervisor's Name
Dates Employed From ___ / ___ / ___ To ___ / ___ / ___	Do we have permission to call <u>main office</u> for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> Do we have permission to call supervisor for verification? Yes <input type="checkbox"/> No <input type="checkbox"/> If no to either, please explain _____	
Reasons for Leaving		

PROFESSIONAL REFERENCES

Please list the names of three professionally related persons, not related to you, whom you have worked with for at least one year.			
Name	Address	Phone	Professional Relationship
		()	
		()	
		()	
Release for contacting references. I hereby authorize All Dental Solutions to contact any of the above references. I further authorize such references to release any information concerning me as they deem appropriate. I release and forever discharge All Dental Solutions, its agents or employees, and the above-named references, and their respective agents or employees, from any and all liability, suits or causes of action arising in any manner from All Dental Solutions contacting and communicating with such references. <i>I understand that this Release prevents me from instituting any claim, lawsuit or other legal action based on any information any reference provides All Dental Solutions.</i>			
Applicant Signature _____		Date _____	

AGREEMENT

The following section contains important information regarding your legal rights and contains important certifications and releases of liability. Please read it carefully before signing.

I authorize All Dental Solutions to contact my current employer before my current employment there ends.

Yes No

I authorize All Dental Solutions to contact my prior employers.

Yes No

I understand that if I am offered employment with All Dental Solutions, prior to or at the time that I start work, I will be required by law to present original documents (I-9) establishing my identity and my eligibility to work in the United States.

Upon termination, I authorize All Dental Solutions to provide information to my prospective employers regarding my employment history and performance and hereby release All Dental Solutions and any person employed by it or associated with it from all liability in connection with the provision of such information.

Unless applicable state or local law provides otherwise, I understand that, if hired, I shall be employed "at will" and that nothing contained in All Dental Solutions employment application, personnel policies, or other written documents, nor any oral statements made to me by All Dental Solutions representatives in connection with my application for employment or at any other time, shall constitute an express or implied employment contract. Unless applicable state or local law provides otherwise, I understand and agree that, if hired, my employment is for no definite period and may be terminated at any time with or without notice or cause.

It is unlawful in Virginia to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

I certify that the facts contained in this Application are true and complete to the best of my knowledge and understand that, if employed, falsified, omitted, or misrepresented statements on this Application may constitute grounds for immediate dismissal.

By signing below, I acknowledge that I have read, understood, and voluntarily agree to the above.

Date: ____ / ____ / ____

Signature: _____