



THE DIAGNOSTIC & TREATMENT CENTER
A Service of Marshfield Clinic and Ministry Health Care

Employment Application

Important message to all candidates for employment

The Diagnostic & Treatment Center recognizes that all persons are entitled to equal opportunities in its recruitment, placement, training, and compensation practices. It is the policy of the company to afford equal employment opportunities to all employees and applicants for employment without regard to age, color, marital status, national origin, race, religion, sex, sexual orientation, or any other characteristic protected by federal, state, or local law and to afford equal opportunities to disabled veterans, veterans of the Vietnam Era, and individuals with disabilities that do not interfere with the person's ability to perform the essential functions of the position.

PERSONAL	Date	Name (first, middle, last)		
	Address		City	State ZIP
	Home telephone number ()		Alternative telephone number ()	
	Email address			Desired wage or salary: \$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per year
	Are you 18 years of age or older: <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you presently authorized to legally work in the U.S. on a full-time basis: <input type="checkbox"/> Yes <input type="checkbox"/> No	

EMPLOYMENT INTERESTS	Position of interest		Date of availability
	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/> Temporary		Can you travel if the position requires: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
	<input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends <input type="checkbox"/> Holidays <input type="checkbox"/> Call <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights		Do you have a valid driver's license: <input type="checkbox"/> Yes <input type="checkbox"/> No
	How were you made aware of the position for which you are applying?		
	<input type="checkbox"/> Newspaper ad Paper _____	<input type="checkbox"/> Internet ad Web site _____	
	<input type="checkbox"/> Staffing agency Agency _____	<input type="checkbox"/> School posting School _____	
	<input type="checkbox"/> Employee referral	<input type="checkbox"/> Job fair Location _____	
<input type="checkbox"/> DTC webpage	<input type="checkbox"/> Other Source _____		

AN EQUAL OPPORTUNITY EMPLOYER

GENERAL INFORMATION

Have you ever been employed with The Diagnostic & Treatment Center, either as a regular or temporary employee: Yes No

Were you ever a student or have you ever done a clinical rotation at The Diagnostic & Treatment Center: Yes No

Have you ever been employed by Marshfield Clinic: Yes No
 If yes, dates of employment and department(s) _____

Have you ever been employed by Ministry Health Care: Yes No
 If yes, dates of employment and department(s) _____

List any relatives who work for The Diagnostic & Treatment Center:
 Name/Relationship _____
 Name/Relationship _____

Do you have any current noncompete agreements or other agreements that might affect your ability to become employed with us: Yes No
 If yes, list company/organization issuing agreement _____

Have you ever been convicted of and/or have any pending charges of any offense (municipal ordinance violation, misdemeanor, or felony) other than minor traffic violations: Yes No

If yes, attach an extra page(s) detailing nature of offense/charge, date, county, and state of any conviction/charge, and any sentence imposed.

NOTE: You are not required to disclose any sealed or expunged records. A conviction does not automatically disqualify you from employment consideration.

Have you ever been or are you currently excluded from participation in any federally funded program, including Medicare and Medicaid: Yes No
 If yes, explain _____

Have you ever been discharged or disciplined in any job, including for a medical record (eletronic or paper) violation: Yes No
 If yes, describe the date, name of employer, and circumstances of the discharge or discipline _____

EDUCATION

Name and Location of School or Training Program	Course of Study	No. of Years Completed	Diploma or Degree Awarded	GPA

SKILLS/KNOWLEDGE

Computer software knowledge:
 Word Other _____
 Excel _____
 Outlook _____

Professional licensure, certification, or registration: Yes No
 State issued _____
 Number _____
 Expiration date _____

List any other experiences, skills, qualifications, or training programs that are related to the position for which you are applying _____

Provide your complete job history, including military service and self employment; attach additional pages, if necessary. Begin with your most recent employer and work backwards. **Even if you provide a resume, this section must be completed; incomplete information may disqualify you from further employment consideration.**

EMPLOYMENT HISTORY	Employer	Address	Starting Date	Ending Date
	Type of business	Job title		
	Supervisor's name	Supervisor's telephone number	Starting Salary	Ending Salary
	Describe work performed (your duties and responsibilities)			
	Do you authorize us to contact this employer: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Casual	
	Were you involuntarily terminated from this position: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for leaving:			
	Employer	Address	Starting Date	Ending Date
	Type of business	Job title		
	Supervisor's name	Supervisor's telephone number	Starting Salary	Ending Salary
	Describe work performed (your duties and responsibilities)			
	Do you authorize us to contact this employer: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Casual	
	Were you involuntarily terminated from this position: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for leaving:			
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Were you involuntarily terminated from this position: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for leaving:				

Please provide information about three professional references.

REFERENCES	Name	Relationship	Daytime Telephone Number(s)

Please read carefully before signing.

I agree that my employment and compensation may be terminated with or without cause and with or without notice at any time at the option of either The Diagnostic & Treatment Center or myself. I understand and agree that terms and conditions of my employment may be changed, with or without notice, by The Diagnostic & Treatment Center. Neither this application, nor any company policy, statement, or practice (whether verbal or written), or the acceptance or continuance of employment is to be construed as a promise of continued employment, or as creating an implied or expressed contract. I certify that all information included on this application is true, complete, and correct. Any false information, omissions, or misrepresentations may lead to denial of my application or, if I am employed, discharge at any time. I understand that The Diagnostic & Treatment Center requires a completed Employment Application and that a resume, though may be provided, does not eliminate the requirement of my completing an Employment Application. I agree to abide by the policies and procedures of The Diagnostic & Treatment Center.

Initials _____ Date _____

I authorize all current and former employers, educational institutions, personnel representatives, and state motor vehicle and transportation departments in reference to this application to answer questions asked by The Diagnostic & Treatment Center. I understand that any information regarding my employment history, character, driving records, etc., can and will be investigated, and I release all persons from all liability and damages that may result from furnishing that information to The Diagnostic & Treatment Center.

Initials _____ Date _____

I understand that The Diagnostic & Treatment Center will require me to undergo a drug screen by a medical staff and/or agent selected by The Diagnostic & Treatment Center as a condition of my employment and/or continued employment. I

further understand that I must successfully pass the drug screen to be considered for employment with The Diagnostic & Treatment Center. I voluntarily consent to provide a urine specimen at a collection facility designated by The Diagnostic & Treatment Center. I also consent to having the specimen screened at a laboratory selected by The Diagnostic & Treatment Center. I further agree that the drug screen results will be disclosed to The Diagnostic & Treatment Center. Refusal to participate will result in rejection of my application. I understand that if I am offered and accept a position with The Diagnostic & Treatment Center, I will be required to have a new-hire health screening by an agent selected by The Diagnostic & Treatment Center as part of the new-hire process and a condition of employment. I understand that The Diagnostic & Treatment Center follows Center for Disease Control (CDC) guidelines and, as such, the new-hire health screening will consist of, among other things, documentation of immune titers for specific diseases and a two-step tuberculosis (TB) test, and that further exams/tests may be required based on results of the initial health screening.

Initials _____ Date _____

I understand that as a condition of my job, I may be required to work overtime, be on call, work on holidays, etc., and agree to fulfill any such job requirements.

Initials _____ Date _____

I further release The Diagnostic & Treatment Center, including all of its officers, agents, representatives, and employees, from any and all claims, suits, causes of action, liability, and damages associated with or arising from my submission to a lawfully administered drug test and/or medical examination. I also understand that The Diagnostic & Treatment Center maintains a scent-free and tobacco-free environment.

Initials _____ Date _____

I have read and agree to all of the above statements.

Signature _____

Date _____



THE DIAGNOSTIC & TREATMENT CENTER

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