



**MICHIGAN COMMUNITY  
DENTAL CLINICS, INC.**  
 One Water Street, Suite 200  
 Boyne City, MI 49712  
 231-547-7638  
 Fax: 231-582-2967

## APPLICATION FOR EMPLOYMENT

Michigan Community Dental Clinics is an equal opportunity employer. It does not discriminate on the basis of race, color, national origin, creed, age, religion, sex, height, weight, marital status, or disabling condition in employment. No person shall be denied employment solely because of any disability which is unrelated to the individual's ability to do the essential functions and duties of the job with or without accommodation. Under state law, a person with a disabling condition may not allege a failure to accommodate a disabling condition unless the employer knew or reasonably should have known that an accommodation was needed.

**Please type or print all information.**

**Return to:** \_\_\_\_\_

### PERSONAL

Date of Application	Date You Can Start	Type of Position You Are Seeking
Name		Telephone Number
Address	City	County State Zip
Are you a United States Citizen? <input type="radio"/> Yes <input type="radio"/> No		Minimum Salary Required
Email Address:		Can we contact you via e-mail? <input type="radio"/> Yes <input type="radio"/> No
Do you have transportation available? <input type="radio"/> Yes <input type="radio"/> No	Do You Wish to Work <input type="radio"/> Full-time <input type="radio"/> Part-time	If Part-time, # of hours you wish to work _____ per week
At what locations are you willing to work?	From what source did you learn of this employment opportunity?	

### GENERAL

Have you ever been convicted of a felony or misdemeanor other than a minor traffic violation? <input type="radio"/> Yes <input type="radio"/> No	If yes, give details.
Are there any current felony charges pending against you? <input type="radio"/> Yes <input type="radio"/> No	If yes, give details.
Driver's License Number:	<b>For all positions, a person regarded as a successful candidate will be required to have a criminal record check and a driver's license check.</b>

### MEDICAL HISTORY

Can you perform the tasks of this job with or without reasonable accommodations? <input type="radio"/> Yes <input type="radio"/> No	If No, which tasks would you be unable to accomplish?
If accommodations are needed, how would you perform the tasks, and with what accommodations?	
<b>A person regarded as a successful applicant will be required to have a pre-employment physical which includes drug testing.</b>	

## EDUCATION

High School Diploma or G.E.D. <input type="radio"/> Yes <input type="radio"/> No	I am licensed or registered in Michigan as a: Expiration Date:
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**For some positions, a person regarded as a successful applicant will be required to provide evidence of education, license, registration, and driver's license.**

Type of Degree	Major	Minor	College, University, or Nursing School and Location	Date Degree Granted	Dates Attended
					From To
					From To
					From To
Branch of Military	Military Rank	Total Years of Service	Related Duties	Skills/Duties	

Professional Internship was completed at:

If applying for a clerical position, indicate job-related equipment you are qualified to operate.

Please provide any additional information such as special skills, training, management experience, computer, word processing, equipment operation, or qualifications you feel will be helpful to us in considering your application.

## PERSONAL REFERENCES

Applicants for professional positions should indicate professional references or agency with which credentials are on file.

Name	Address	Phone

**CURRENT AND FORMER EMPLOYERS (Attach extra pages if necessary)**

List your present employer first, list every promotion as a new job. Please explain all periods of unemployment.

Employer Name and Address  Name of Supervisor: _____ Phone Number: _____ May we contact this employer as a reference? <input type="radio"/> Yes <input type="radio"/> No	Position Title	Salary: (per _____) Starting _____ Ending _____
	<input type="radio"/> Full-time <input type="radio"/> Part-time	From ____/____ to ____/____
	Number of Employees You Supervised	
	Reason for Leaving	
Description of Your Duties: _____ _____ _____		
Employer Name and Address  Name of Supervisor: _____ Phone Number: _____ May we contact this employer as a reference? <input type="radio"/> Yes <input type="radio"/> No	Position Title	Salary: (per _____) Starting _____ Ending _____
	<input type="radio"/> Full-time <input type="radio"/> Part-time	From ____/____ to ____/____
	Number of Employees You Supervised	
	Reason for Leaving	
Description of Your Duties: _____ _____ _____		
Employer Name and Address  Name of Supervisor: _____ Phone Number: _____ May we contact this employer as a reference? <input type="radio"/> Yes <input type="radio"/> No	Position Title	Salary: (per _____) Starting _____ Ending _____
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	Number of Employees You Supervised	
	Reason for Leaving	
Description of Your Duties: _____ _____ _____		
Employer Name and Address  Name of Supervisor: _____ Phone Number: _____ May we contact this employer as a reference? <input type="radio"/> Yes <input type="radio"/> No	Position Title	Salary: (per _____) Starting _____ Ending _____
	<input type="radio"/> Full-time <input type="radio"/> Part-time	From ____/____ to ____/____
	Number of Employees You Supervised	
	Reason for Leaving	
Description of Your Duties: _____ _____ _____		

Have you ever been employed by MCDC? <input type="radio"/> Yes <input type="radio"/> No	If Yes, please complete the following: Dates employed _____ to _____ Clinic _____ Reason for termination of employment _____
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Have you previously applied to MCDC?  Yes  No

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

I understand that, prior to being offered employment, I will be requested to take an employment physical examination and drug testing. In the event that I have a disability which will affect my ability to take the tests, I will so inform the Agency prior to the administration of the test so that a reasonable accommodation can be made. The Agency 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 and understand that, if employed, falsified statements on this application may result in termination.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be continued based only on satisfactory performance and conduct.

I authorize investigation of all statements contained in this application for any employment-related purpose. I release the listed references and all employers, except those specifically excepted, \* to provide you with any and all applicable information they have. I hereby release these references and former employers from all liability for any information they may give to you.

\_\_\_\_\_ Date \_\_\_\_\_ Signature

\*Employers specifically excepted: \_\_\_\_\_