

Dental Search Inc.
7 Spielman Road
Fairfield, NJ 07004
973-575-9581

Profession _____

Date: ____/____/____

Name _____

Address _____

(City) _____ (State) _____ (Zip) _____

Cell Phone () _____

Home Phone () _____

Work Phone () _____

SS# _____

E-mail address _____

Who to contact in case of an emergency: _____

I am seeking: ____ Permanent work ____ Temporary work ____ Part time ____ Full time

EDUCATION: SCHOOL LOCATION YEARS COMPLETED DEGREE

High School _____

College _____

Additional _____

EMPLOYMENT HISTORY (show present or most recent position first)

Employer _____ Address _____

Dates: From _____ to _____ position _____ Supervisor _____ Title _____

May we call this employer for references? Yes _____ No _____ Phone () _____

Salary: Start _____ End _____ Type of Business _____

Duties and functions:

Reason for leaving: _____

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Employer _____ Address _____

Dates: From _____ to _____ position _____ Supervisor _____ Title _____

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OVER

Please give 2 character references:

	(Name)	(Address)	(Phone)	(Occupation)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Have you ever worked or were educated under another name? _____ if yes explain _____

Are you a U.S. Citizen or an alien authorized to work in the U.S.? _____

Have you ever been convicted of a crime? _____ Explain _____

Do you have any disability/medical condition that would prevent you from performing the job you are applying for? _____

Please explain: _____

How did you hear about us? _____

Do you hold a valid drivers license? Yes _____ No _____

Do you hold a valid license in:

RADIOLOGY yes _____ no _____ License #: _____

C.D.A. yes _____ no _____ License #: _____

R.D.A. yes _____ no _____ License #: _____

DENTAL HYGIENE yes _____ no _____ License #: _____

EXPANDED DUTIES yes _____ no _____ License #: _____

DENTIST yes _____ no _____ License #: _____

CPR yes _____ no _____ Other professional licensing yes _____ no _____

Do you have computer knowledge? yes _____ no _____

If yes, what software? Please list them; _____

DO YOU HAVE DIGITAL X-RAY Knowledge? Yes _____ No _____

Do you have LATEX ALLERGIES, or other medical conditions? Yes _____ No _____

If yes, list them and explain; _____

HOURS AND DAYS AVAILABLE : _____

Position desired: _____ Salary desired: _____ Least desired _____

What are your short term career goals? _____

What are your long term career goals? _____

Where have you interviewed or sent your resume? _____

***I understand that the acceptance of this application does not constitute an offer of employment with Dental Search Inc. or guarantee employment at any time. Acceptance of this application places my name on the active registry, eligible for placement with a dental office when and if work becomes available. I further understand that my registration and acceptance of work assignment through Dental Search means that I cannot return to or accept any employment, permanent or otherwise, from any dental office or organization without first notifying D.S.I., I understand that I may be removed from the active registry and held liable for the entire permanent placement fee.

Upon acceptance of any assignments, I understand that I am required to comply with the reasonable instructions of the dental office/organization with which I am placed subject to professional standards. In addition I understand that failure to comply with any reasonable instructions from the dental office/organization may result in the removal of my name from the active registry.

(Requirement of the Federal Government for Your Protection)

I hereby acknowledge the filing of my application with Dental Search to assist me in securing employment.

I understand that an investigative report may be obtained by Dental Search Inc. and presented to prospective employers for evaluation. This investigative report may include information concerning my character, personal characteristics, general reputation, mode of living, and financial resistibility. I further understand that I have the right to make a request to Dental Search Inc. to learn the complete nature and scope of this investigative report.

I certify that I have read and understand the above statements and hereby authorize Dental Search Inc. to obtain a report as described above and to verify any information contained in this application. I understand that in the event that any statement contained in this application is untrue, that my name shall be removed from the registry.

Signature _____ Date: _____

DO NOT WRITE BELOW THIS LINE

Application sent by mail: _____ yes _____ no

Interview conducted by: _____

Travel: _____ Days available/time _____

LD _____ DH _____ X _____ CDA _____ RDA _____ DDS _____ MAL _____ CONSUB _____ OTHER _____