

Please mail the completed application to:

**Dentserv
15 Canal Road
Pelham Manor, New York 10803**

Applications can also be faxed to **914.738.0331**.

All applications should be completed in their entirety and include:

- *Two reference request forms (enclosed)*
- *Consent and release authorization form (enclosed)*
- *Photocopies of any certificates of training that would be helpful in reviewing your application*

Hygienists must also enclose the following:

- *A photocopy of your New York State triennial registration*
- *A photocopy of your malpractice policy indicating name of carrier, type and extent of coverage and expiration date.*

Application For: _____ Date: _____

Position Desired: _____

I understand that this employment application and any other company documents are not contracts of employment, and that any individual who is hired may voluntarily leave employment upon proper notice, and may be terminated by the employer at any time for any reason. I understand that any oral or written statements to the contrary are hereby expressly disavowed and should not be relied upon by any prospective or existing employer.

Print Name _____
Last First Middle

Address _____
Street City State Zip

Telephone Home _____ Office _____

This information is needed to complete our records in the event of employment: Social Security # _____

Show below a continuous record of your employment. Please Print. Give last employment first.

Period of Employment / Name and Address of Employer
From To

Mo. _____ Yr. _____ Position _____

Name _____

Street _____

City _____ State _____ Zip _____

Phone Number() _____

Reason for leaving: _____

Period of Employment / Name and Address of Employer
From To

Mo. _____ Yr. _____ Position _____

Name _____

Street _____

City _____ State _____ Zip _____

Phone Number() _____

Reason for leaving: _____

OK to check references YES() NO() Signature _____

RECORD OF EDUCATION

<u>Type of School</u>	<u>Name & Address</u>	<u>Dates</u> <u>From/To</u>	<u>Graduated</u>	<u>Major</u>
High School				
College				
Post Graduate				
Business or Trade				
Other				

Referred by: _____

Salary Requirements for position Desired: _____

Full Time () Part Time () Per Diem () On Call ()

Days () Evenings () Nights () Weekends ()

As an employee I agree to follow an on call schedule if required:

Signature: _____ Print: _____

Have you ever been convicted of a crime? Yes () No () If so explain.

What office machines can you operate: _____

LICENSE:

All employees who are required to be licensed, please complete.

License # _____ Expiration Date _____

Permit # _____ Expiration Date _____

If eligible for license, when will you take the exam _____

MEDICAL HISTORY

NAME: _____

DATE: _____

Please answer whether you have (or had) any of the following and give date of onset:

- Typhoid Fever Yes No date of onset _____
- tuberculosis Yes No date of onset _____
- Diabetes Yes No date of onset _____
- Mental or Emotional illness Yes No date of onset _____
- Epilepsy Yes No date of onset _____
- Back Problems Yes No date of onset _____
- Cardiac Problems Yes No date of onset _____
- Hypertension Yes No date of onset _____
- Chicken Pox Yes No date of onset _____
- Infectious Mononucleosis Yes No date of onset _____
- Hepatitis A or B Yes No date of onset _____
- Blood/lymph disease
 - Leukemia or Hodgkins Yes No date of onset _____
 - Other _____ Yes No date of onset _____

If you have answered yes to any of the above, please explain: _____

Do you take corticosteroids (prednisone, cortisone)? Yes No If yes please explain: _____

Are you taking any immunosuppressive drugs (azathioprine, cycloserine, muromonab)? Yes No If yes, please explain: _____

List all currently prescribed medications:

Are you habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances? Yes No If yes, please explain: _____

Please list all allergies, if any: _____

If you have been hospitalized in the past 5 years, please explain and give details (include year, diagnosis, surgery and treatment): _____

If you have had a major illness in the past, please explain and give details: _____

Please check one of the following:

I am applying for a position as a Dental Assistant []

I am applying for a position as a Dental Hygienist []

In accordance with current Federal Regulations and NYS Public Health Law you are required to respond to the following questions. If you answer yes to any of these questions you must provide a detailed explanation.

I.

Have you ever been, or currently in the process of being denied, revoked, suspended, reduced, limited, terminated, placed on probation, not renewed, voluntary or involuntary relinquished, or have you ever withdrawn or failed to proceed with an application for the following, if applicable:

A professional license/registration

Yes[] No[]

Employment at any health care facility or practice

Yes[] No[]

Professional liability insurance

Yes[] No[]

Any other type of professional sanction

Yes[] No[]

II.

Have you ever been named as a defendant in a criminal proceeding?

Yes[] No[]

III.

Have you ever been investigated or censured for violation(s) of patient rights?

Yes[] No[]

If you have answered yes to any of the above questions please provide details on the back of this form or on a separate sheet of paper. Include dates names and addresses

Medical History continued

Tuberculosis Screening

1. Do you have any of the following symptoms:
If Yes Please Explain

Fever Yes No _____
Tiredness Yes No _____
Weakness Yes No _____
Night Sweats Yes No _____
Loss of Appetite Yes No _____
Unexplained Weight Loss Yes No _____
Swelling in Neck, Armpits Groin Yes No _____
Cough with Sputum Yes No _____
Blood Tinged Sputum Yes No _____

2. Do you have a history of induration, sensitivity, and/or allergy to PPD testing?
 Yes No Date of Last PPD _____ Results: Negative _____ Positive _____
3. Have you ever received a course of prophylactic treatment for TB?
 Yes No If yes, complete the following:
Start Date: _____ End Date: _____
Medications: _____
4. Have you received a BCG vaccine within the past 10 years?
 Yes No If yes, date of BCG Vaccine: _____

Do you have any physical or medical conditions which may limit your ability to perform your particular duties? Yes No If yes, please explain _____

STATEMENT OF APPLICANT

The above information is true. I understand if I qualify for the position and if I pass the physical examination I will be employed. I agree to abide by the policies established by Dentserv Dental Services P.C. I authorize inquiries of any kind of my former employers or other sources as to my experience, character, habits, or reasons for leaving and further authorize Dentserv Dental Services P.C. to release such information without liability. I further understand and agree that any misrepresentation of this information may be cause for dismissal.

SIGNATURE OF APPLICANT

PRINT

DATE

THE CIVIL RIGHTS ACT OF 1964 PROHIBITS DISCRIMINATION BECAUSE OF RACE, COLOR, RELIGION, OR NATURAL ORIGIN. PUBLIC LAW 90-202 PROHIBITS DISCRIMINATION BECAUSE OF AGE. THE LAWS OF NEW YORK STATE PROHIBIT DISCRIMINATION DUE TO AGE, SEX, RELIGION, RACE, COLOR, CREED, NATIONAL ORIGIN, MARITAL OR MILITARY STATUS, AND PHYSICAL AND MENTAL HANDICAP. AN EQUAL OPPORTUNITY EMPLOYER.

HYGIENISTS ONLY

Licensure / Certification

LICENSURE

Answer the following question(s). If the answer is yes, you must provide a full explanation* below or attach a separate sheet.

Have any disciplinary actions been initiated, or are any pending against you by a licensing board in this State or any other State?

YES [] NO []

Has your license to practice in this state or any other state ever been denied, limited, or been voluntarily or involuntarily suspended or revoked?

YES [] NO []

List all states by which you are, or have ever been licensed to practice dentistry. Include license numbers and dates issued. All licenses must be listed even if no longer in effect.

OTHER LICENSES:

STATE	LICENSE#	DATE ISSUED	DATE OF EXPIRATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If additional space is required please attach a separate sheet)

*EXPLANATION:

INSTITUTIONAL AFFILIATIONS - HYGIENISTS ONLY

Answer the following question(s). If the answer is yes, you must provide a full explanation on a separate sheet and attach.

Has your employment, Medical staff appointment, or privileges ever been suspended, diminished, revoked, or refused at any hospital or other health care facility?

Yes [] No []

Have you ever voluntarily or involuntarily resigned from Medical Staff appointment, clinical privileges, or employment at any hospital, other health care facility or organization?

Yes [] No []

List in chronological order ALL health care affiliations within the last ten (10) years. Complete addresses must be included. If more space is needed attach additional sheets.

Institution

Name: _____

from: _____ To: _____

Category of Appointment: _____

Address: _____

Department: _____

Chairman: _____

Institution

Name: _____

from: _____ To: _____

Category of Appointment: _____

Address: _____

Department: _____

Chairman: _____

DISCIPLINARY ACTIONS - HYGIENISTS ONLY

In accordance with the current State and Federal regulations we are required to ask and you are required to respond to the following questions. If the answer to any of the questions is yes, full explanation must be provided.

Has your association, employment, practice and/or privileges at any hospital or health care facility ever been limited or discontinued for any reason?

YES [] NO []

Have you ever been involved in any medical, dental, or other misconduct proceedings in this State or any other State?

YES [] NO []

Have you ever been involved in any medical, dental, or other malpractice actions in this State or any other State?

- YES [] NO [] * If YES was the matter:
- a. settled prior to final court action? [] yes [] no
 - b. judgement rendered by court? [] yes [] no
 - c. defendant found liable? [] yes [] no
 - d. matter still pending [] yes [] no

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program?

YES [] NO []

Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

YES [] NO []

Have you ever been named as a defendant in any criminal proceeding?

YES [] NO []

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization?

YES [] NO []

HYGIENISTS ONLY
PROFESSIONAL LIABILITY INSURANCE

List all professional liability insurance carriers for the previous ten (10) years. If additional space is needed, please attach sheet.

Carrier Name: _____ Address _____
 Policy#: _____
 Coverage Limits: _____
 Expiration Date: _____

Carrier Name: _____ Address _____
 Policy#: _____
 Coverage Limits: _____
 Expiration Date: _____

Carrier Name: _____ Address _____
 Policy#: _____
 Coverage Limits: _____
 Expiration Date: _____

Have any professional liability suits ever been filed against you in this State or any other state? Yes [] No []

*If yes, review the attached history currently on file and report any additional actions or changes in status below:

Pending Action(s)

Name of Claimant	Date of Occurrence/Action	Nature of Claim	Status
_____	_____	_____	_____
_____	_____	_____	_____

Judgements/Settlements

Name of Claimant	Date of Occurrence/Action	Nature of Claim	Status
_____	_____	_____	_____
_____	_____	_____	_____

Consent and Release

I fully understand that any significant misstatement in or omissions from this application for appointment/reappointment constitute cause for denial of appointment or cause for summary dismissal from the Dentserv Dental Services, P.C. staff. All information submitted by me in this application (including attachments) is true to my best knowledge and belief. I agree to update this application should there be any change in the information provided.

In making this application for appointment/reappointment of Dentserv, I acknowledge that I have received and read the service agreement and rules and regulations. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to Dentserv.

By applying for appointment/reappointment to the Dentserv staff, I hereby signify my willingness to appear for interviews in regard to my appointment/reappointment, authorize Dentserv, its staff and their representatives to consult with administrators and members of medical staff of other hospital or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, professional societies, specialty boards and professional schools and training programs who may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability Dentserv, all representatives of Dentserv, and its staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Dentserv, or its staff, in good faith and without malice concerning my professional competence, ethics character and other qualifications for staff appointment/reappointment and clinical privileges, and I hereby consent to release of such information.

I hereby further authorize and consent to the release of information by representatives of Dentserv, or its staff, to other hospital and healthcare facilities, or their medical staffs, licensing boards and medical associations on request regarding any information Dentserv and the staff may have concerning me as long as such release of information is done in good faith, with out malice, and in accordance with Federal and State laws, and I hereby release from liability Dentserv, its staff and their authorized representatives to the full extent permitted by law for so doing. Nothing in this documents shall be construed as limited or superseding any immunities otherwise provided by law.

I understand and agree that I, as an applicant for staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I agree that further verification of my identity may be obtained if deemed necessary by Dentserv, (by use of my photograph). I will not participate in any form of illegal fee-splitting.

Signature: _____

Date: _____

Name Typed/Printed: _____

INSTRUCTIONS FOR COMPLETING REFERENCE FORMS

Please fill out only the section entitled "TO BE COMPLETED BY APPLICANT". Make sure that you fill out the employer data box. Sign and date only this section. Do not write below this section. Return these two reference forms with the rest of your application. If you do not have a complete address for your reference, please provide a telephone number.

EMPLOYMENT VERIFICATION REQUEST	DENTSERV 15 Canal Road Pelham Manor, NY 10803
---------------------------------------	---

TO BE COMPLETED BY APPLICANT

Applicant Data Name: _____ Address: _____ _____	Employer Data Name: _____ Address: _____ _____
---	--

Dates of employment were _____ to _____
 Position held: _____
 Reason for leaving: _____

I hereby authorize the employer listed above to release
 confidential information about my employment to Dentserv.

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYER

- Was the applicant employed on the dates listed? Yes No
- Was his/her position as stated above? Yes No
- Did the applicant leave for the reason stated? Yes No
- Would you re-hire the applicant? Yes No

Please rate the applicant's performance in the following areas:

- | | | | | | | |
|---------------------|--------------------------|------|--------------------------|----------|--------------------------|------|
| Applicant's health: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |
| Quality of work: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |
| Productive output: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |
| Attendance: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |
| Cooperation: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |
| Initiative: | <input type="checkbox"/> | Good | <input type="checkbox"/> | Adequate | <input type="checkbox"/> | Poor |

Other comments (your remarks are most important)

Completed by: _____
 Title: _____
 Date: _____

Please return this form to
 Dentserv at the above
 address. Your assistance
 in this matter is greatly
 appreciated.