HCMII

HEALTH CARE MANAGEMENT INTERNATIONAL INC.

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APPLICATION FOR EMPLOYMENT

Return this form with RESUME to

HCM International Inc.
145 Traders Blvd. Unit # 36, Mississauga, L4Z 3L3. Ontario, Canada
☎ 1(905) 712 0436
Fax: 905- 712 2485

Position Desired / Area of Preference or Specialty		Date of Application
Last Name	First Name	Middle Name
Social Security Number	Telephone Number Home	Work
Address		Apt. No
City	State	Zip Code
Emergency Contact Name		Relationship
Address		Phone
Minimum Salary Desired	Date you can start	State your citizenship
Give your Visa Status and Alien Registration No.		

EDUCATION

If you were educated or employed under a different name (e.g. maiden name, citizenship name change, etc) please indicate for purposes of verifying credentials and references)

Institution	Address	From (mo/yr) to (mo/yr)	Major Field/Degree	Did you graduate?
High School				☐Yes ☐No
College				☐Yes ☐No
Other				☐Yes ☐No
Graduate School				☐Yes ☐No

EMPLOYMENT HISTORY

If you were educated or employed under a different name (e.g. maiden name, citizenship name change, etc) please indicate for purposes of verifying credentials and references)

Employer Name	Job Title	Date of Employment (Include Month/Year)
Address	Supervisor's Name	Phone May we check this reference? ☐Yes ☐No ☐ Full Time ☐ Part Time Salary
Reason For Leaving	Duties Performed	
Employer Name	Job Title	Date of Employment (Include Month/Year)
Address	Supervisor's Name	Phone May we check this reference? ☐Yes ☐No ☐ Full Time ☐ Part Time Salary
Reason For Leaving	Duties Performed	
Employer Name	Job Title	Date of Employment (Include Month/Year)
Address	Supervisor's Name	Phone May we check this reference? ☐Yes ☐No ☐ Full Time ☐ Part Time Salary
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Address	Supervisor's Name	Phone May we check this reference? ☐Yes ☐No ☐ Full Time ☐ Part Time Salary
Reason For Leaving	Duties Performed	

I affirm the information g en is true and correct. I understand that false or misleading information may result in my dismissal. Further, by completion and submission of this form, I authorize you to secure all information in connection with my application for employment. This may include matters of opinion, character, conduct, reputation and ability. I authorize and request each company, organization and/or individual named herein to furnish the requested information. I understand a physical examination is required, and should I fail to pass or if for any reason it is determined that I am not qualified for employment, I may not be employed and you shall not be liable for loss or damage as a result.

Signature of Applicant ______________________________________ Date ____________________

SKILLS & QUALIFICATIONS

☐ Type (wpm) Familiarity with medical terminology	Others (office, mechanical, etc)
Language spoken and read fluently	

Professional, trade or technical Registration or license	Type	No.	Date Issued
Passport No.			Expiration Date

Memberships in scientific / professional organizations you consider relevant to the job you are seeking:

ADDITIONAL INFORMATION

Do you have any physical, mental or medical impairment that could interfere with your ability to perform the job you are seeking? ☐Yes ☐No

If Yes, please explain.

Have been convicted of any crime? (Felony or misdemeanour) ☐Yes ☐No

If yes, state each crime for which convicted, the date of conviction and the court where convicted. Please note: A police clearance may be required to obtain a visa for specific countries.

Would you be willing to accept an unaccompanied (i.e. no spouse or children) status position? ☐Yes ☐No

Comments

How did you hear about us?

❑ Journal	List Name	❑ Referral	List Name
❑ Web site	List Name	❑ Other	List Name

This space may be used to expand upon any previous entry or to provide detailed information you consider pertinent to your prospective employment.

REFERENCE AUTHORIZATION

I understand that considerable effort on the part of HCM International Inc (or its subsidiaries) may be expended in considering me for a position. Such efforts may include a personal interview and reference checks exploring my past performance on the job as well as character references. I authorize HCM International Inc. to contact my past employers or educational institutions. I further authorized all past employers / educational institutions and all offices of record to release any information that will facilitate a full evaluation of my qualifications for possible employment.

SIGNATURE	**PRINT NAME**
Social Security Number	

Please list the names of THREE (3) work related supervisory level references:
We require current letters of reference from these present and past supervisors who have worked with you within the past five (5) years.

Name	Professional relationship
Phone number	Hospital / Institution
Fax number	Best time to call
Address	Best time to call
Have you attached a reference letter? ☐Yes ☐No If No, when can we expect it?	

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Phone number	Hospital / Institution
Fax number	Best time to call
Address	Best time to call
Have you attached a reference letter? ☐Yes ☐No If No, when can we expect it?	

Name	Professional relationship
Phone number	Hospital / Institution
Fax number	Best time to call
Address	Best time to call
Have you attached a reference letter? ☐Yes ☐ No. If No, when can we expect it?	

MEDICAL QUESTIONAIRRE

Please select the appropriate column if you have or have had the following complaints or symptoms or if you have been advised to seek treatment for:

#	Complaint or Symptom	Yes	No	#	Complaint or Symptom	Yes	No
1	Heart Attack			13	Multiple Sclerosis		
2	Kidney Stones			14	Arthritis		
3	Stomach or Duodenal Ulcer			15	Advised to have surgery		
4	Muscular weakness-paralysis			16	Difficulty seeing		
5	Need to wear orthopaedic braces/appliances			17	Difficulty hearing		
6	Backache			18	Seizures (convulsion)		
7	Asthma			19	Stroke		
8	Hernia			20	High blood pressure		
9	Diabetes Mellitus			21	Frequent Headaches		
10	Tumour or Cancer			22	Ever tested + for Hepatitis B?		
11	Emotional Stress			23	Ever tested + for Hepatitis C?		
12	Herniated Disc						

What medicines do you take	List frequency and reason
Average Weekly consumption of tobacco	Average Weekly consumption of alcohol

Explanation of YES Answers Above

Medical Care/Hospitalization in past 10 years

Date	Reason	Surgery Performed?	Result of treatment or surgery.

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Signature of Applicant _____ Date _____