



**EDUCATION AND SKILLS**

High School \_\_\_\_\_ City & State \_\_\_\_\_  
 Year Graduated or Highest Grade Completed \_\_\_\_\_

| Colleges and Universities Attended | City and State | Years Attended |    | Major and Minor Subjects | Degree and Year Granted |
|------------------------------------|----------------|----------------|----|--------------------------|-------------------------|
|                                    |                | From           | To |                          |                         |
| Undergraduate Education            |                |                |    |                          |                         |
|                                    |                |                |    |                          |                         |
| Graduate Education                 |                |                |    |                          |                         |
| Residency/Postgraduate Training    |                |                |    |                          |                         |
|                                    |                |                |    |                          |                         |

List any other courses, studies of training leading to certificate, diploma, or degree:

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**LICENSES/CERTIFICATIONS/SPECIALTIES**

List all current and past licenses:

| State | License No. | Date Issued |  | Expiration Date | Status |
|-------|-------------|-------------|--|-----------------|--------|
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
|       |             |             |  |                 |        |
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List any honors received since graduation from college. (fellowships ,honorary degrees, etc.)

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**TEACHING EXPERIENCE**

| Name and Location of School | Rank and/or Title | Teaching Field | Years |    | Salary |
|-----------------------------|-------------------|----------------|-------|----|--------|
|                             |                   |                | From  | To |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |
|                             |                   |                |       |    |        |

**EXPERIENCE OTHER THAN TEACHING**

| Position | Employer | Address | Years | Salary |
|----------|----------|---------|-------|--------|
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |
|          |          |         |       |        |

**List publications (magazine articles, books, monographs, etc.), giving title, where publishes, and date:**

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**List active membership in professional organizations**

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**PROFESSIONAL REFERENCES**

List individuals other than those listed elsewhere in this application who have observed your clinical performance during a recent period.

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

|                |              |                 |                                  |
|----------------|--------------|-----------------|----------------------------------|
| <b>Name</b>    |              |                 | <b>Professional Relationship</b> |
| <b>Address</b> |              |                 | <b>Length of Relationship</b>    |
| <b>City</b>    | <b>State</b> | <b>Zip Code</b> | <b>Phone Number</b>              |

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**APPLICANT'S CERTIFICATION**

I certify that answers given herein are true complete to the best of my knowledge, I authorize the Morehouse School of Medicine to make such investigations and inquiries of my employment history and other related matters as may be necessary in arriving at an employment decision. I hereby release employers, schools or person from all liability in responding to inquiries connection with my application for employment.

I make this statement to the Morehouse School of Medicine with knowledge that any false or misleading information may be sufficient cause for dismissal.

Applicant's Signature \_\_\_\_\_ (Degree) \_\_\_\_\_ Date \_\_\_\_\_



**MOREHOUSE SCHOOL OF MEDICINE**

**(PLEASE ANSWER ALL QUESTIONS – PLEASE PRINT)**

**Human Resources**

The Civil Rights Act of 1964 and ADA (Title I) prohibits discrimination in employment with regard to race, color, religion, sex, national origin, age, marital status, physical or mental status, physical or mental handicap, disability or veterans status.

To help Morehouse School comply with Federal/State equal employment opportunity record keeping, reporting and other legal requirements, please answer the questions below.

**Note:** This Pre-employment information form will be kept in a confidential file and will have no bearing on your application.

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**APPLICANT: DOCUMENTS WILL NOT BE RETURNED AFTER SUBMITTED**

**Date:** \_\_\_\_\_

**Position(s) applying for:** 1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Middle

**Address:** \_\_\_\_\_  
Number and Street City State Zip Code

**Telephone:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

**Are you a U.S. Citizen?**  Yes  No **If No, are you authorized to work in this country?**  Yes  No

**If yes, what is your Visa status?**  J-1  HIB  Other \_\_\_\_\_

**Race/Ethnic Group**  Black  White  Hispanic  American Indian  
 Asian  Pacific Islander  Other \_\_\_\_\_

**Sex**  Male  Female **Marital Status**  Single  Married  Divorced  Separated

**Vietnam Era Veteran**  Yes  No **If Yes, what is your Disability rating?**

**Vietnam Veteran**  Yes  No

**\*Employment Eligibility and Identity Documents will be Required at Time of Hire.**



# MOREHOUSE SCHOOL OF MEDICINE

Human Resources

## **RELEASE OF INFORMATION (Supplemental to Employment Application)**

### **AN EQUAL OPPORTUNITY EMPLOYER**

I hereby give my consent and authorization to the MOREHOUSE SCHOOL OF MEDICINE and/or its designee to obtain any information, which is relevant to my application for employment. Any person(s) or organization(s) are directed to furnish such information upon request.

This release of information is given with my full knowledge and understanding.

With my signature below, I release any person(s) or organization(s) and their employees, agents and officials, acting in an official capacity, from any liability for complying with this release.

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**APPLICANT'S SIGNATURE**

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**DATE**

**APPLICANT INFORMATION RELEASE**

I hereby authorize Morehouse School of Medicine and/or Vericon Resources, Inc. and/or any of their authorized agents to gather information regarding the following: All records including criminal, credit, driving, drug, and/or education; written or verbal information from previous employers; any other pertinent information relating to the function of my job.

I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check, and are asked for legitimate nondiscriminatory reasons. Responses to sex, age, and race inquiries are voluntary, and choosing not to respond will not preclude hire or promotion. I hereby release Morehouse School of Medicine employees, former employees, other references, and Vericon Resources, Inc. and any of its authorized agents from liability, and understand there is no invasion of privacy.

I understand that submission of false information on this or any employment form may result in non-selection or in termination if hired. The following is my complete legal name, and all information is true and correct to the best of my knowledge. This information is used for verification purposes ONLY:

|   |   |  |  |
|---|---|--|--|
| <b>Last Name, First Name, Middle Initial (PLEASE PRINT LEGIBLY)</b> |   | <b>Position Applying For:</b>              |  |
| <b>Applicant's Signature</b>  |   | <b>Driver's License Number &amp; State</b> |  |
| <b>Social Security Number</b>                                       | <b>Responses to the questions in this section are optional and voluntary, for ID Only</b> |  |  |
| <b>Date of Birth</b>  | <b>Race</b>   | <b>Sex</b>                                 | <b>M <input type="checkbox"/> F <input type="checkbox"/></b> |
| <b>Former Names and Time Frames (if applicable)</b>                 |   |  |  |
| <b>Current Address</b>  | <b>City/State</b>   | <b>Zip/County</b>                          | <b>Dates (Mo/Yr.)</b>  |
| <b>Previous Addresses (Past 7 Years)</b>                            |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |

**FOR MOREHOUSE SCHOOL OF MEDICINE OFFICE USE ONLY:**

**Please complete the following section:**

|   |                                 |   |
|---|---------------------------------|---|
| <b>Please Check Services Requested:</b> |                                 |   |
| Crim <input type="checkbox"/>           | Credit <input type="checkbox"/> | MVR <input type="checkbox"/>              |
| Drug <input type="checkbox"/>           | Educ <input type="checkbox"/>   | Employ <input type="checkbox"/>           |
| Ref <input type="checkbox"/>            | Other <input type="checkbox"/>  | (specify on fax) <input type="checkbox"/> |
| <b>Contact Name</b>                     | <b>Phone #</b>                  | <b>Date</b>                               |

Phone: 770/457-9922  
 800/795-3784  
 Fax:800/915-1020

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