Advanced Family Eye Care Employee Candidate Form

Name_____ DOB _____

Address_____

Phone _____Email _____

Most recent employer _____

Reason for leaving _____

May we contact your current/most recent supervisor? ____ Yes ____ No

Supervisor Contact Info _____

If not, why _____

Last wage earned: _____ per hour or _____ per yr

Hourly Expectation: _____

Do you require health insurance benefits? _____

General Hours:
8:00-5:00 pm Mon- Tues, Thursday- Friday, Wed; 8:30 – 5:00pm
Do you have any scheduling issues/commitments that may interfere with work hours?

_____

_____

How soon would you be able to start if hired?_____

References:_____

_____

Thank you for your time!