EYE CARE PROFESSIONALS OF WESTERN NEW YORK, LLP

3364 Sheridan Dr. Amherst, NY 14226 Ph: 716-833-2020
2290 Main St. Buffalo, NY 14214 Ph: 716-835-1105
750 Dick Rd. Cheektowaga, NY 14225 Ph: 716-684-1622
4703 Transit Rd. Depew, NY 14043 Ph: 716-656-2011

PERSONAL

Last Name	First Name	Midl. Init	
Present Address	Apt # / City	State	Zipcode
Primary Telephone #		U. S. Citizen?	Yes ☐ No ☐
Email Address:		Age 18 or older?	Yes ☐ No ☐
Position Applying for:		If related to anyone in our employ, give name:	
Would you accept another position? Yes ☐ No ☐			
What starting salary will you accept?	Date Available	☐ Full-time ☐ Part-time	Days/Hours Available

Were you previously employed by ECP? [ ] Yes [ ] No If yes, complete as follows

Location: _____ From: _____ To: _____

Position Held: _____

Have you ever been convicted of a crime? [ ] Yes [ ] No If yes, explain

School	Name and Location	Course of Study	Circle Last Year Completed	Did You Graduate?	Last Diploma or Degree
High School			(1) (2) (3) (4)	[ ] Y [ ] N	
College			(1) (2) (3) (4)	[ ] Y [ ] N	
Other (Specify)			(1) (2) (3) (4)	[ ] Y [ ] N	

Please list Professional Licenses: _____ No.(s) _____ Expiration _____

Certificate or Permits held: _____ No.(s) _____ Date(s) _____

SKILLS

Check Your Skills

[ ] Computer [ ] ICD9 Coding [ ] Microsoft Word

[ ] CPT Coding [ ] Knowledge of Medical Terminology [ ] Microsoft Excel

Visual Acuity ☐	Tonometry ☐	Visual Fields ☐	Optician
Contact Lenses ☐	Frame Stylist ☐	Pretesting ☐	

Other:

Employment History

From:	Name of Employer	Name of Supervisor		
To:	Address	City	State	Zip Code
Telephone #		Salary	Per	
Briefly Describe the work You Performed	May we Contact this Employer?		☐ Yes	No ☐
Reason for Leaving				
From:	Name of Employer	Name of Supervisor		
To:	Address	City	State	Zip Code
Telephone #		Salary	Per	
Briefly Describe the work You Performed	May we Contact this Employer?		☐ Yes	No ☐
Reason for Leaving				
From:	Name of Employer	Name of Supervisor		
To:	Address	City	State	Zip Code
Telephone #		Salary	Per	
Briefly Describe the work You Performed	May we Contact this Employer?		☐ Yes	No ☐
Reason for Leaving				

Personal References (No Former Employers or Relatives)

Name and Occupation	Address	Telephone
Name and Occupation	Address	Telephone
Name and Occupation	Address	Telephone

Military Service

Branch of Service	From:	To:	Rank at Discharge
Nature of Duty and Special Training			

I Authorize Name (Former Employer)

Address	City	State/Zip

To Disclose to Eye Care Professionals of Western New York
Information Concerning My Employment with Them.

Signature Date

I Authorize Name (Former Employer)

Address	City	State/Zip

To Disclose to Eye Care Professionals of Western New York
Information Concerning My Employment with Them.

Signature Date

I Authorize Name (Former Employer)

Address	City	State/Zip

To Disclose to Eye Care Professionals of Western New York
Information Concerning My Employment with Them.

Signature Date

Eye Care Professionals of Western New York facilities are smoke free.
Smoking is not permitted in any of our facilities.

Print

I certify that by submitting this application, that all matters contained in this application are true, authorize their investigation and agree that any misleading or false statements would render this application void, and would be sufficient cause for immediate dismissal in the event of employment. I also understand that my employment is dependent on receipt by Eye Care Professionals of satisfactory references and attendance at employee orientation.This relationship is employment at will.